National Conference *on*

Making Early Abortion Safe and Accessible

October 11-13, 2000 Agra, India

Ministry of Health & Family Welfare, Govt. of India

Parivar Seva Sanstha and Ipas

REPORT

NATIONAL CONFERENCE ON MAKING EARLY ABORTION SAFE AND ACCESSIBLE

October 11-13, 2000
AGRA, INDIA

Ministry of Health & Family Welfare, Govt. of India
Parivar Seva Sanstha
Ipas

Participants alongwith Secretary, Family Welfare (Govt. of India)

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Background

- *Abortion Status*
- *Population Policy 2000*
- *Way Forward*

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BACKGROUND

Abortion Status

The Medical Termination of Pregnancy (MTP) Act of 1971 was the most enlightened piece of legislation of its time, which made abortions legal. Despite this liberal law, access to safe and legal abortion services remains a major problem. No reliable data is available on the extent of unsafe/ illegal abortions in India. According to the Sample Registration Survey (SRS) of 1998, 8.9% of all maternal deaths (407 maternal deaths per 100,000 live births) are due to unsafe abortions i.e. 9000 to 10000 maternal deaths per year and many more women are impaired permanently by complications.

Many women lack access to safe, quality and legal services, because of lack of availability of recognized abortion service delivery centres, competent service providers, confidentiality and compassion of the services, as well as lack of knowledge regarding its legal status.

Population Policy 2000

In the Population Policy released early 2000 by Government of India, under section 46 (ix) of the chapter on "Promotional and Motivational Measure for Adoption of the Small Family Norm" it is stated, " Facilities for safe abortion will be strengthened and expanded". Further, under the National Population Policy, 2000 Action Plan (Appendix – I, para – B) ten operational strategies to remove the barriers limiting women's access to safe abortion services have been identified. These are as quoted :-

- Community – level education campaigns should target women, household decision makers and adolescents about the availability of safe abortion services and the dangers of unsafe abortion.
- Make safe and legal abortion services more attractive to women and household decision makers by (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality and (iv) providing compassionate abortion care, including post-abortion counseling.
- Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependent upon anaesthesia, or non-surgical techniques which are non-invasive.
- Promote collaborative arrangements with private sector health professionals, NGOs and the public sector, to increase the availability and coverage of safe abortion services, including training of mid-level providers.
- Eliminate the current cumbersome procedures for registration of abortion clinics. Simplify and facilitate the establishment of additional training centres for safe abortions in the public, private, and NGO sectors. Train these health care providers in provision of clinical services for safe abortions.
- Formulate and notify standards for abortion services. Strengthen enforcement mechanisms at district and sub-district levels to ensure that these norms are followed.
- Follow norms-based registration of service provision centres, and thereby switch the onus of meticulous observance of standards onto the provider.
- Provide competent post-abortion care, including management of complications and identification of other health needs of post-abortion patients, and linking with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counseling and services such as sterilization, and re-

versible modern methods such as IUDs, as well as oral contraceptives and condoms.

- Modify syllabus and curricula for medical graduates, as well as for continuing education and in-house learning, to provide for practical training in the newer procedures.
- Ensure services for termination of pregnancy at primary health centres and at community health centres.

Ten operational strategies to remove the barriers limiting women's access to safe abortion services have been identified. These are:

- Community level education
- Making legal services more attractive
- Adoption of updated simple and safe technology
- Collaboration amongst public, private and NGO sectors, including training of midlevel providers
- Simplification of registration procedures of clinics and training of health care providers
- Ensuring adherence to newly formulated standards
- Switching the onus to providers for following standards
- Provision of competent post abortion care, including contraception
- Inclusion of practical training in newer procedures in syllabus and curricula.
- Ensuring availability of services in PHCs and CHCs

Way Forward

A series of concerted and simultaneous bold initiatives to create demand for safe and legal quality services are therefore immediately required to alter the present grim situation. The Ministry of Health and Family Welfare (MOHFW), Government of India (GOI) recognizes this. Already, some decisions have been taken to move forward. Amongst these is the resolve to collaborate with experts to chalk out a well-informed and considered direction for change. Early this year, Ipas, an international NGO, that focuses on the issue of unsafe abortion worldwide, Parivar Seva Sanstha, a premier national NGO working in the field of reproductive health and with experience of over 20 years in delivering safe and legal abortion services in the country, and the Department of Family Welfare, Ministry of Health and Family Welfare, Government of India, decided to collaborate to organize a technical meeting on abortions. The preparations for the conference involved considerable planning with active support and guidance from officials in MOHFW. It was decided that the consultation should be very focussed and the aim should be to derive the maximum impact in the shortest period to make abortion services safe and accessible in the country. The action plan under the Population Policy 2000, along with the existing data was thoroughly evaluated.

It was concluded that to begin with, if only Ist trimester pregnancies, i.e upto 12 weeks of gestation, were managed by competent service providers at easily accessible and recognized service centres, then maternal mortality and morbidity could be immediately and significantly brought down. This is possible as it is estimated that about 80% of all the abortions in the country are within the Ist trimester. Moreover, experiences from developed and some of the developing countries have shown that abortions during first trimester can be made very safe in simple settings with minimal facilities as compared to the 2nd trimester abortions. Therefore it was decided to focus on early abortion procedures in the 1st trimester and develop appropriate strategies through national consultation to make abortion services simpler, safer, accessible and affordable at all levels.

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Conference

- *Organisation*
- *Aim*
- *Participants*
- *Inaugural Session*
- *Proceedings*
- *Presentations*
- *Group Discussions*

THE CONFERENCE

Organization

The National Conference on "Making Early Abortion Safe and Accessible" took place in Agra for 2 equivalent working days and was a joint endeavour of GOI, PSS and Ipas. The financial support was provided mainly by Packard Foundation, Wallace Global Fund, DFID and Sida.

Aim

The **overall objective** of the conference was to develop Action Plans and recommendations for implementing select safe early abortion strategies as contained in the Population Policy, 2000.

The **specific objectives** being:

- To review the obstacles and opportunities for early safe abortion services in India
- To review both Indian and International experiences with methods for termination of Ist Trimester gestations
- Provide new recommendations for improved early abortion access concerning:
  - Service delivery site certification process
  - Training requirement and certification for providers
  - Training centre requirements

Participants

A total of 44 participants belonging to Central and State governments and ICMR, professional bodies such as FOGSI and Nursing Council of India, NGOs such as FPAI, ARTH, CEHAT PSS; international agencies like Population Council, Ford Foundation, Sida, UNFPA, WHO, Rockefeller Foundation, MSI and Ipas as well as reputed gynaecologists from the academic institutions and the private sector participated. Also there were three international delegates, one each from Johns Hopkins University, USA (with international experiences on MVA technique); South Africa (a country which recently implemented a modern abortion law and initiated a series of actions to increase access to safe abortions) and Bangladesh (official adoption of a successful Menstral Regulation programme upto 8 weeks by para-medical personnel, inspite of abortion not being legal) who participated and presented their countries experiences on early safe abortion services.

A list of participants is attached as **Annexure I**

Inaugural Session

Wednesday 11th October, 2000 at 6 pm : all the invited delegates registered themselves and the inaugural session started.

Mrs. Sudha Tewari, Managing Director, Parivar Seva Sanstha welcomed the participants. She hoped that with the announcement of the recent National Population Policy-2000, there would be an expansion of the availability of safe abortion services. It was important to focus attention on those aspects which could have immediate and maximum impact on the abortion services in India – and after consultations with the GOI and Ipas, she stressed that the

deliberations and discussions should narrow down to "Making Early Abortion Safe and Accessible". She hoped the meeting would be as interactive as possible and looked forward to participation from all the delegates. She thanked all the donors – Packard Foundation, Wallace Global Found, DFID and Sida for making the conference possible with their contributions.

On behalf of Ipas, Mr. Don Weedon, Regional Director (Asia) of Ipas also welcomed the participants and thanked the GOI for their support in making this conference possible. He hoped the participants would arrive at concrete recommendations to help "Making Early Abortion Safe and Accessible".

The conference then was inaugurated by Shri A R Nanda, Secretary(Family Welfare), Ministry of Health and Family Welfare, Government of India. Shri Nanda said that his Ministry was highly concerned with poor access to and utilization of safe abortion services in the country as well as lack of adequate facilities for performing safe abortions. He also outlined several steps being taken by his Ministry to mitigate the present situation. Shri Nanda urged the eminent participants from different parts of the country and abroad to deliberate fruitfully and sort out some of the special issues such as use of Manual Vacuum Aspiration (MVA) procedure in early abortions, involvement of midlevel providers in service delivery as well as operational strategies contained in the Population Policy 2000. He further said that the Conference recommendations would help the Government in taking decisions in making early abortions safe and accessible to all women in every part of the country. (Mr. Nanda's speech is in **Annexure- IV-A**)

The objectives and format of the conference was then presented and explained to the delegates, by Dr. Sneh Vishwanath, Medical Advisor of Parivar Seva Sanstha. The inaugural session was then followed by a welcome dinner to all the delegates and invitees.

Inaugural Address by Mr. A.R. Nanda, Secretary, (Family Welfare) MOHFW, Govt. of India

Momento being given to Mr. A.R. Nanda, Secretary, (Family Welfare) MOHFW, Govt. of India

Proceedings

The first two specific objectives of the conference was achieved by spending half a day on presentations and discussions and the third one

through group work on assigned topics, presentation of the group reports, followed by discussions.
The Agenda adopted during the conference is presented as **Annexure - II**.

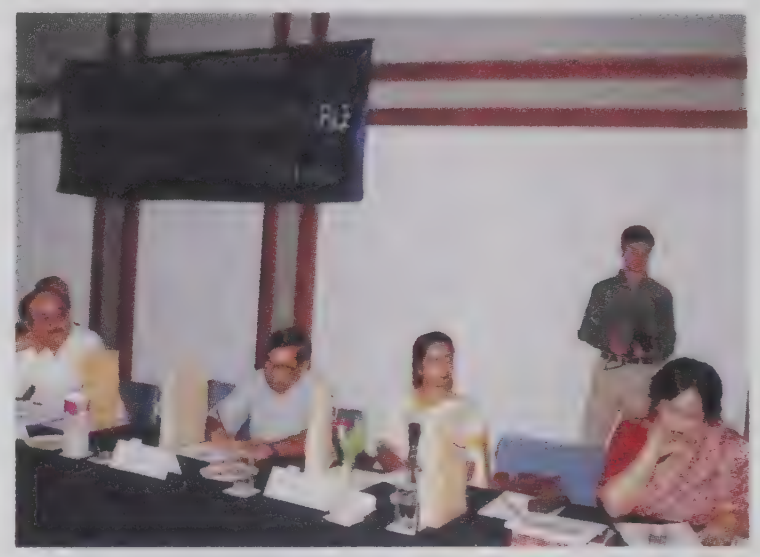
Presentations

Dr Saroj Pachauri provided the participants with an excellent overview of the abortion services in the country, obstacles being faced by the service providers as well as the women and raised pertinent questions that needed to be addressed during the meet. Dr. Saroj Pachauri also enumerated how access to safe abortion care can be enhanced within the current policy environment.

Mr. A.R. Nanda, Secretary, Family Welfare, Govt. Of India, Dr. Saroj Pachauri, Regional Director Population Council and Mrs. Sudha Tewari, Managing Director, PSS.

Mr. Don Weeden, Ipas; Dr. Vishwanath, PSS; Mr. Gautam Basu, Joint Secretary, Family Welfare, GoI and Dr. V. K. Manchanda, Deputy Director General, Maternal Health, GoI along with other participants.

Dr. Alokendu Chatterjee, President FOGSI, (1999-2000) presenting a momento to Dr. Halida Hanum Akhtar Director, BIRPERHT, Bangladesh, Ms. Teresa McInerney Programme Associate IPAS.



Ms. Yasmin Zaveri Roy, Programme Officer, SIDA, with other participants.

This was followed by a presentation on **'decentralizing early abortion services' by Dr Nozer K Sheriar.** Different current abortion practices along with their complications were discussed. He also analysed the MTP Act and Rules and highlighted some of the ways that early abortion services could be made more widely available.

The **global perspective** on early abortions was provided by **Dr. Paul Blumenthal**. He compared the

Dr. Kim Dickson-Tetteh of South Africa, Ms. Geetanjali Misra of Ford Foundation and Dr Kalpagam and Ms. Poonam Arora of PSS

Dr. Paul Blumenthal of Johns Hopkin University, USA aongwith Dr. D.K. Tank and Dr. Kuhu Maitra

experiences worldwide of vacuum aspiration over Dilatation and Curettage (D&C) as well as comparing Electric Vacuum Aspiration (EVA) and MVA separately. The advantage and simplicity of the use of MVA in early abortions was highlighted. The need for proper training of service providers on the MVA technique was stressed for a successful MVA programme.

A conference on early abortion procedures would not have been complete without a presentation on **medical abortion** from **Dr. Kurus Coyaji**, who presented his experience of nine years with this method in Pune, both in urban and rural areas. When a combination of oral administration of mifepristone (Ru486) and Misoprostone was offered to women, 85% of the women opted for this method, with a compliance of 98% and 97% efficacy of the procedure. The side effects were minor, such as nausea, vomiting and some prolonged bleeding.

Dr Halida Akhter from the neighbouring country **Bangladesh** gave an overview of the several years old **MR programme** under which menstrual regulations are being carried out upto 10 weeks. Dr. Halida discussed how unsafe clandestine abortions in the country have been brought down by increasing access to safe abortion services through female paramedical staff who have been trained in the Menstrual Regulation (MR) with MVA technique and are providing services in the rural areas. This cadre of providers are thus supplementing the efforts of the doctors. She cautioned that the two critical issues of skill training and supervision needed to be addressed.

The rationale behind **decentralizing the early abortion services in South Africa** through the recent legislation of "The Choice on Termination of Pregnancy Act, 1997" was discussed by **Dr. Kim Dickson-Tetteh**. She informed that in addition to medical practitioners, registered midwives are terminating pregnancies upto 12 weeks after having received training so that access to safe abortion services (a reproductive right of women)are available at the primary health care level to women. Dr. Kim Dickson Tetteh emphasized the training of doctors and midwives in MVA technique, post abortion family planning counselling and the importance of evaluating the training and services.

The presentations ended with the **experience of Parivar Seva Sanstha** in early abortion services in India by Dr. B. Kalpagam. The presentation highlighted the experience of PSS in MVA technique for Ist trimester abortion services for over 20 years in different parts of the country. Data on current client profile, facilities, equipment and instruments, type of anaesthesia, complications and post abortion contraception was also presented.
(Detailed presentations in **Annexure – IV**)

Work Group discussions

Participants were then divided into four work groups with representations in each from various categories of personnel. The makeup of each group is attached as Annexure-III. The various discussion topics were–

Group– I : Service delivery requirements and site certification upto 8 weeks;
Group– II : Service delivery requirements and site certification upto 12 weeks;
Group– III : Service provider's training requirements and certification;
Group– IV: Training centres and trainers development.

Each work group spent half day in discussing the allotted topics with discussion guidelines and came out with their set of recommendations, which were presented to the larger group and discussed on the last full day to arrive at the recommendations.
(Details of workgroup presentations in **Annexure – III**)

Workgroup - 1 *: Discussed on Equipment for Site Certification upto 8 weeks.*
Dr Sharad Iyengar (Facilitator), Dr. Kuhu Maitra (Rapporteur) and other members - Ms. Teresa McInerney, Dr. Kamini Rao, Dr. Lisa Thomas, Dr. Halida H Akhtar, Dr. Veena Mathur and Dr. A Banerjee

Workgroup - 2 *: Discussed on Equipment for Site Certification upto 12 weeks.*
Dr. D.K. Tank (Facilitator), Dr. Nozer Sheriar (Rapporteur) and other members - Dr. V. K. Behal, Dr. Paul Blumenthal, Dr. D.K. Ghorai, Dr. B. Kalapagam, Dr. Sangeeta Kaul, Dr. V. Pendse, Dr. Rajiv Sharma

Workgroup - 3*: Discussed on Provided Training requirments.*
Dr V.K. Manchanda (Facilitator), Dr. Reva Tripathi (Rapporteur) and other members - Dr. Chandrawati, Dr. Chandrashekhar, Dr. A. Chatterjee, Dr. Kim D. Tetteh, Ms. Karen Otesea, Dr. Prakasamma, Dr. Sneh Vishwanath

Workgroup - 4*: Discussed on Increasing Training Capacity.*
Dr Dinesh Agarwal (Facilitator), Ms. Poonam Arora (Rapporteur) and other members - Dr. Kalpana Apte, Dr. N. K. Biswas, Dr. Kurus Coyaji, Dr. Ravi Duggal, Mrs. R. Gujral, Dr. N. C. Saxena, Mr. Don Weeden

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Recommendations

- *Common Theme*
- *Specific Recommendation*

III. RECOMMENDATIONS

As planned, the proceedings of the conference arrived at recommendations for the following three areas of concern i.e. :

1. Service delivery requirements and site certification for upto 8 weeks, and for 12 weeks of gestation of pregnancy.
2. Service providers' training requirements and certification.
3. Training centres and trainers' development.

The recommendations follow this narrative.

Common Themes

While the workgroups considered separate issues, several common themes emerged from the deliberations :

1. Without any further delay **immediate changes** can be brought about in the current situation for safe early abortion services in the country. It was recommended that the **MOHFW develop standards and procedural guidelines for abortion services** segregated into 3 main gestational categories: (i) Upto 8 weeks (ii) upto 12 weeks and (iii) pregnancies in the Second Trimester, upto 20 weeks.

   The new standards /guidelines would apply to all MTP service delivery sites, both in public and private sectors.

   The resulting standards/guidelines, along with specific instructions and clarifications on specific certification criteria in form of a Government Order (GO), would ease the registration process immediately. Also, it was recommended that the MoHFW immediately delink the MTP service provider from the certification of MTP service site, an existing practice currently being followed without any rationale.

2. As already proposed by the Government, the **MTP certification process** should be **decentralized** from State to District level.

3. In order to remove some more barriers to making safe and legal abortion services more affordable and accessible, there is a definite **need to amend the existing Medical Termination of Pregnancy Rules, 1975.** This step would reduce the excessive emergency equipment now required for abortion service facilities which are unnecessary for carrying out 1st trimester abortions. Under new amendments the equipment requirements would depend on the period of gestation, with the first semester requiring less and simpler equipment.

   The specific recommendations in the three areas are provided here, which now needs to be formalised. In addition, it is necessary that the amendments are far sighted, taking into account the potential for medical abortion.

   Amendments to the Rules can be done in the

short term as notification in the Official Gazette by the Central Government is adequate.

4. The potential to involve paramedics and Ayurvedic medical providers in MVA service delivery for early gestations should be tested through pilot studies in different regions. Once their potential competency in providing this service has been ascertained, **amendments to the existing Medical Termination of Pregnancy Act, 1971 can be developed and taken up**. A thoroughly tested competency based skills training program will be necessary to ensure that these cadres of providers are prepared well to safely deliver MVA services.

   The current syllabus and curricula of the Ayurvedic stream of ISM practitioners needs to be studied in greater depth.

   Also, only nurses with BSc degree or diploma are to be included under midlevel provider.

5. Both knowledge and skill of MVA method of abortion must be introduced to the medical students during their basic MBBS course. For this, some amendment in the existing MCI curriculum / syllabus may be required.

6. A national strategy should be developed for expanding training capacity for abortion procedures, with emphasis on MVA training. The number one priority should be to train and certify thousands of MBBS doctors already working in the public health system, especially in MVA.

   NGOs and private hospitals should be encouraged and facilitated to play an important role in increasing MTP training capacity.
   To strengthen abortion services in the peripheral areas, there is need to incorporate some **policy changes** like (a) OBGYN training for MBBS doctors already in the govt. system (3 to 4 months) should be made essential prior to PHC posting; and (b) doctors who have done rural posting in PHC should get preference in post graduate seats.

7. To have effective communication and client–provider interactions, counselling and communication skills should be imparted to all students in medical college teaching. Also all ANM / FP staff working in different FW clinics should be trained in counselling, during their pre and inservice training.

8. The private sector and NGOs should be encouraged and facilitated to expand abortion services, particularly in undeserved areas of the country, and need to be integral to any MTP expansion plan.

SPECIFIC RECOMMENDATIONS

Introduction

- There is little difference between early abortion (upto 8 weeks) and MTPs through the full first trimester (upto 12 weeks) in clinical practice. However, medical procedure between 8 to 12 weeks, may require greater provider skill and experience, in view of the marginal increase in the risk of complications.
- The recommendations covered service delivery requirements and site certification requirements only for surgical abortions. The implications due to **medical abortion,** an imminent reality needs to be discussed and included.
- The group covering abortions upto 12 weeks were of the view that stipulations for site certification should be rationalized, and the emphasis shifted to training of providers so that the implications are clearly understood and standards maintained.

Service delivery requirements for First Trimester MTP only

S.NO	*ISSUE*	*FOR GESTATION UPTO 8 WEEKS*	*FOR GESTATION UPTO 12 WEEKS*	*REMARKS*
01	Type of method to be used	MVA/EVA (optional)	MVA / EVA	- general comment - may be covered under Government Order (GO) Guidelines
02	Functional area & physical facility	- Facility should have proper privacy with space for counselling, performing procedure and post procedure recovery	Facility should have room of adequate size (size need not be specified)	- Under "approval of place", Rule 4(i) of 1975, safe and hygienic conditions has been specified. However, in reality, the authorities insist on different areas and specific sizes for operation theatre /procedure room. Therefore a need to issue clear GO.

S.NO	ISSUE	FOR GESTATION UPTO 8 WEEKS	FOR GESTATION UPTO 12 WEEKS	REMARKS
		- Arrangements for clean water, running water preferable		- Recommended that first trimester MTPs may be performed at a primary health centre or comparable facilities in the private or NGO sector. - A need to allot suitable facilities to PHC for RCH services. - Many PHCs not manned by suitable medical staff.
03	Equipment/ Instruments	- Ordinary gynecological examination table - MVA syringe and plastic canulae of sizes 4,5,&6, vaginal speculum, volsellum and sponge holders	– ordinary gynecological examination/ procedure table, allowing lithotomy position. - Surgical set for gynecological examination, and VA – MVA/ EVA (plastic canulae 4 to 10 nos., speculae, volsellum/ tenaculum, sponge holder, ovum forceps & dilator and curette (for emergency use only) - Instrument /equipment for abdominal/ gynecological surgery not required. - Capacity to provide IV infusion. - Reasonable light for gynecological, examination -	- Rule 4(ii) a of 1975 specifies, "facility of operation table and instruments for performing abdominal or gynecological surgery." - Need to modify the above Rules. - Details to be incorporated in GO. - There are no significant differences in the facilities required for upto 8 weeks or upto 12 weeks in the conduct of the procedure, time taken or complications. The facilities to be established are largely comparable, except for larger canuale needed for EVA. The occasional dilatation required may mean enhanced training.

S.NO	ISSUE	FOR GESTATION UPTO 8 WEEKS	FOR GESTATION UPTO 12 WEEKS	REMARKS
			spot light or torch, (OT light not required) .	
04	Anaesthetic equipment		No requirements for anaesthetic equipment (No Boyles apparatus , no O_2 supply)	- Clear GO to be issued so that inspecting authorities do not insist on Boyle's apparatus and O_2 cylinders.
	Resuscitation equipment	Oral airways and Ambu bag	No requirement for resuscitation equipment	- Rule 4(ii) b of 1975 to be modified to delete anaesthetic and resuscitation equipment. and modify requirement of sterilization.
	Sterilization equipment	Either on-site or use of off-site sterilization processing	Facility for either on site or off site processing - Decontamination - Cleaning - High level disinfection by boiling/ chemical disinfection or sterilization as required	
05	Drugs and parental fluids for emergency use	Essential items to manage emergency condition	Drugs like adrenaline, atropine, antihistaminics, uterotonics – oxytocin, methylergometrine or prostaglandins, antiemetics, intravenous fluids and infusion sets	
06	Management of complications	Centre should perform initial clinical assessment of the condition, and stablise the client, then refer to higher	Identification and management as part of training protocol. Facilities to manage not necessary on site.	- Indirectly linked, to Rule 4(ii) a of 1975, but need not be specified in the rule. - To be covered as Guidelines in the GO

S.NO	ISSUE	FOR GESTATION UPTO 8 WEEKS	FOR GESTATION UPTO 12 WEEKS	REMARKS
		referral centre (either with transport to the referred site or a physician to the site)	However repair of local cervical trauma may be feasible as well as management of hemorrhage	
07	Site Certification Process	A district level certification committee to be established, as follows: - Both public and private/ NGO to be included. - Consist of about 5 people from CMO's office, NGO, local IMA etc. - Check list for site certification required - One person to visit the site - Fee for certification, which could meet the costs of the committee - Time limit for registration to be indicated/ and registration by default	- Application at District authority CMO /DHO/ Civil Surgeon - Inspection by designated expert committee - Recognition presumed within 90 days if not cleared or rejected. - Option to reapply to higher authorities - Certification not linked to personnel or to the blood bank facilities	- GOI has already initiated a modifications to the Rules of 1975 relating to site certification at the District level. - Additional recommendation to be incorporated - either in the Rules or GO Guidelines. - No. of persons in the district committee were debated as a large number was considered to be counter productive. - The existing practice is different in different districts/ states where the site certification is being linked to personnel available. This to be discontinued immediately. Also other stipulations such as availability of blood banks within specified distance to be deleted through guidelines in GO
08	Patient Selection		- Address as a part of training protocol, not certification (May cover previous CS, severe medical disorders, anaemic included)	- May be covered under Guidelines.

Providers Training and Certification

Eligible Service providers

- For all gestations, medical practitioners as currently defined. Status quo to continue.
- In future, medical practitioners with basic MBBS degree and with 1st trimester abortion training during internship to be included.
- For gestations upto 8 weeks of pregnancy, Ayurvedic practitioners from the ISM (after evaluating their syllabus and curriculum) to be included. Also, nurses with BSc degree / diploma (after evaluating their competency following outcome of the pilot tested project) to be included.
- For introducing the last two changes, the MTP Act would have to be amended.

Training

- All MTP service providers must undergo proper skill training prior to performing abortion services.
- The skill training must be competency based and not dependent upon the number of cases assisted/performed alone.
- The course should have both theoretical and practical aspect, with emphasis on clients centered quality services and identification & management of expected complications.
- To cut down the duration of training, the theoretical part can be imparted through home study course module following distant learning principle.
- The clinical skill training should be one to one basis and not in group. Prior to obtaining practical skills through clients, efficiency and speed can be improved by working on models.
- To facilitate skill training - off-site skill training can be imparted by certified trainers (from public/ NGO/private sectors) at the place of work of the service providers/ recognised MTP centre.
- Training in counselling and communication skills is important
- It is important that the trainer uses a checklist to ensure critical issues are covered during the training.

Certification

- Certification of MTP service providers following completion of training is to be given by the respective trainers who have imparted the competency based training.
- The same authorities monitoring should be authorized to take away registration if the trainee is found to be wanting during follow up.

Monitoring and Evaluation

- Periodic evaluation and supportive supervision of the trained service providers should be ensured at their site of service delivery by any one of the recognised MTP trainers from a nearby place. Gynaecologists are preferred for such evaluations.

Training Centres criteria

- Must be a recognised MTP service site, regularly providing abortion care services.
- It can be any MTP service site in public, NGO and private sector.

Trainers development

- Trainers for MTP skill training can be from public/ NGO/private sectors and of the categories - (i) OBGYN specialists; (ii) MBBS doctors who are regularly performing MTP services for at least three years independently and assessed to have adequate competency.
- All the identified trainers must undergo standardised Training of Trainers (TOT) skill course before imparting MTP training.
- Trainers must be taught communication skills.
- Standardised curricula to be adopted along with steps spelt out.

Trainers Certification

- MTP training centres and trainers are to be certified by a team drawn from public sector officials from Central /State / District level and specialists of OBGYN and NGO/private sectors.

Monitoring and Evaluation

- Periodic monitoring and evaluation needs to be done by any member of the above team to check the quality of training, renewal and withdrawal of certification.

Capacity Building

- To increase capacity of training centres and trainers – both presently and in the future-all district hospitals, selected public sector facilities like urban hospitals, CHCs, FRUs (first referral units) and NGO/private sector facilities should be included along with the existing ones in the country.
- To strengthen MTP training and expanding its access, there is need to evolve some strategic plans which are – (a) make funds available for training to the training centres; (b) immediate reimbursement of travel cost and per diem to the trainees / trainers by the training centre; (c) effective utilisation of high case load training centres by taking more trainees from other site/state/sectors; and (d) involve national NGOs/private sector bodies to impart MTP training.

Other Recommendations

- The equipment and drugs for resuscitation necessary, if any, need to be specified.
- MTP service site certification – the process needs to be identified / spelt out, particularly for NGO and private sectors.
- Involvement of mid-level providers in providing MTP services – who should they be (nurses/ ANM/ISM practitioner's)? What sort of basic skill level they should have? What type and duration of skill training do they need? What will be the course content?
- Criteria of selection of MTP training centre – years of existence, available facilities and number of abortion cases performed per year need to be spelt out.
- Skill practice by the trainee i.e. number of abortion cases to be performed by each trainee before certification of competency as MTP service provider needs to be spelt out.
- The detailed minimum standard for skill training of the service providers needs to be worked out. Also, skills need to be carefully defined. Training course details to be worked out.
- The criteria of certification of MTP service providers and trainers and who should be responsible needs to be worked out.
- The process of supervision and monitoring of both the MTP service sites/providers and MTP training centres/ trainers needs to be worked out.
- The modalities to expand MTP training centres at peripheral public sector sites, NGO and private sector need to be specified in terms of resource and manpower.
- Ways need to be found for personnel available presently to be trained.
- Gender issues need to be particularly addressed, such as increased access to female providers instead of male providers.
- It should be the responsibility of the provider to take the patient to the referral centre, if he finds that he has taken on a client beyond a particular gestation.
- Issue of medical abortion needs to be addressed
- De-registration on surprise visits to be enforced. This must cover the public sector also.
- Research designs for conducting pilots with paramedics/ midlevel providers to be evolved.
- The possibility of inservice training for all the team members at PHC level, using MTP camp approach (as in West Bengal) to be explored.

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Conclusion

IV. CONCLUSION

Mr Gautam Basu, Joint Secretary, MOHFW, was briefed about the recommendations of the conference. In his concluding remarks he said that he was satisfied with outcome of the conference, and reiterated the Government of India's commitment to bring down maternal mortality to less than 100 by 2010. He restated the urgency for provision of safe, accessible and affordable abortion services both at the urban and rural areas, and that this effort would require the joint efforts of public, private and NGO sectors.

Mr. Basu beautifully summarized the recommendations of the conference in terms of the following outcomes : (i) to recognise MVA as the standard method of early abortion; (ii) to develop regulations to facilitate large scale use of private and NGO sector's service delivery sites along with the public sector; (iii) to create opportunities for partnership between government and NGO/ Private sectors both in training and service delivery; (iv) to explore possibilities to involve mid level providers in the service delivery; and (v) to amend the existing MTP act and rules.

He also suggested to Mrs. Sudha Tewari, Managing Director, PSS that the conference should be followed up with the constitution of a "working group" as early as possible. The working group can work on all the issues related to safe abortion services and come out with a package, which can help Government of India in the formulation and implementation process. This will include follow-up and consultations with the state governments and all other stakeholders. It is hoped that this process will gain political support in making early abortion safe and accessible.

Mr. Basu concluded his remark by suggesting to have more frequent meeting of this kind at least once a year to review what has been accomplished and what to be done next, as this conference represents a major beginning for a partnership between public, NGO and private sectors. (Detailed speech of Mr. G. Basu is in **Annexure –IV - I**)

Mr. Don Weeden, Regional Director – Asia, Ipas, thanked Mr. Gautam Basu for his concluding remarks and his critical assessment of the conference proceedings. He also commended the Government of India's commitment to making abortions safe and accessible. Mr. Weeden, also thanked the GOI for their strong participation, and thanked the other participants from State Government, NGOs, professional bodies, OBGYN experts, FOGSI members and nursing council for their commendable work which has resulted in such fruitful outcome. He noted the importance of FOGSI's commitment to making year 2001 the year of "Safe Abortion Saves Lives?" as declared by Dr. Kamini Rao the incoming President for the year 2001. Lastly he thanked PSS for organising this conference so meticulously and Government of India for agreeing to the need for such a meeting following their initial three meetings with Mr. A. R. Nanda, Secretary (Family Welfare) and Mr. Gautam Basu, Joint Secretary (Family Welfare).

5

Annexures

- *List of Participants - Annexure I*
- *Agenda - Annexure II*
- *Work Groups*

  Distribution & Reports - Annexure III
- *Presentations*

  - Annexure IV (A,B,C, D, E, F, G, H, I)

NATIONAL CONFERENCE ON "MAKING EARLY ABORTION SAFE AND ACCESSIBLE"

(a technical meeting to facilitate implementation of measures outlined in the Population Policy, 2000)

11th to 13th October, 2000

Venue : Mughal Sheraton, Agra

List of Participants

	Name/Designation/Address	Tel. No. / Fax No./Email address
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** Did not attend although confirmed intent to participate*

NATIONAL CONFERENCE ON "MAKING EARLY ABORTION SAFE AND ACCESSIBLE"

(a technical meeting to facilitate implementation of measures outlined in the Population Policy, 2000)

11th to 13th October, 2000

Venue : Mughal Sheraton, Agra

Agenda

PURPOSE

The meeting aims to develop action plans for select safe early abortion strategies as contained in the Population Policy, 2000.

THE MEETING WILL

- Review the obstacles and opportunities for safe early abortion services in India.
- Review both Indian and international experiences with methods for termination of 1st trimester gestations.
- Provide new recommendations for improved early abortion access concerning :
  - Service delivery site certification process.
  - Training requirements and certification for providers.
  - Training center requirements.

SCHEDULE

DAY – 1, 11th October, 2000

1.	Registration	All participants	06.30 – 07.00 pm
2.	Welcome to the participants	Ms. Sudha Tewari, Managing Director, PSS Mr. Don Weeden, Regional Director – Asia, Ipas	07.00 – 07.15 pm
3.	Inaugural address	Mr. A. R. Nanda, Secretary, (FW) MoHFW, GoI	07.15 – 07.45 pm
4.	Objectives and format of conference	Dr. S. Vishwanath, Medical Advisor, PSS	07.45 – 08.00 pm

RECEPTION AND DINNER ***08.00 pm onwards***

DAY – 2, 12th October, 2000

1.	Introductory remark	Ms. Sudha Tewari, Managing Director, PSS	08.30 – 08.45 am
	Facilitator :	***Ms. Sudha Tewari, Managing Director, PSS***	

2.	Current situation of abortion in India	Dr. Saroj Pachauri, Regional Director – South East Asia, Population Council	08.45 – 09.15 am
3.	Decentralizing early surgical abortion services	Dr. Nozer Sheriar, MTP Committee, FOGSI	09.15 – 09.35 am
4.	Global Experiences of early surgical abortion services	Dr. Paul Blumenthal, Professor, OBGYN, Johns Hopkins University	09.35 – 10.05 am
5.	Medical methods of early pregnancy termination	Dr. Kurus Coyaji, Gynae. Consultant, KEM Hospital, Pune, India	10.05 – 10.15 am
6.	Discussions		10.15 – 11.15 am
TEA			***11.15 – 11.45 am***
	Facilitator :	***Ms. Teresa McInerney, Programme Associate, Ipas***	
7.	MR Program in Bangladesh	Dr. Halida Akhtar, Director, BIRPERHT, Bangladesh	11.45 – 12.05 pm
8.	Decentralising early abortion services in South Africa	Dr. Kim Dickson – Tetteh, Clinical Director, RH Research Unit, Chris Hani Baragwanath Hospital, Soweto, South Africa	12.05 – 12.25 pm
9.	PSS experience of early abortion services	Dr. B. Kalpagam, Consultant, PSS	12.25 – 12.45 pm
10.	Discussions		12.45 – 01.45 pm
LUNCH			***01.45 – 02.45 pm***
11.	Work Group Orientation and format	Dr. A. Banerjee, QOC Manager, PSS	02.45 – 03.00 pm
12.	Work Group Meet	All participants	03.00 – 06.00 pm

DAY – 3, 13th October, 2000

1.	Work Group continues		08.30 – 09.20 am
2.	Work Group Report (Group 1)	Rapporteur – Dr. Kuhu Maitra	09.20 – 09.50 am
3.	Work Group Report (Group 3)	Rapporteur – Dr. Reva Tripathi	09.50 – 10.20 am
4.	Discussions	All participants	10.20 – 10.50 am
TEA			***10.50 – 11.20 am***
5.	Work Group Report (Group 2)	Rapporteur – Dr. Nozer Sheriar	11.20 – 11.50 am
6.	Work Group Report (Group 4)	Rapporteur – Ms. Poonam Arora	11.50 – 12.20 pm

7.	Discussions	All participants	12.20 – 12.50 pm
LUNCH			***12.50 – 01.50 pm***
8.	Consensus on Recommendations	Ms. Sudha Tewari, Managing Director, PSS	01.50 – 03.20 pm
9.	Reaction and Next Steps by Government	Mr. Gautam Basu, Joint Secretary, MoHFW, GoI	03.20 – 03.50 pm
10.	Concluding session	Mr. Don Weeden, Regional Director-Asia, Ipas	03.50 – 04.00 pm
TEA			***04.00 – 04.30 PM***

WORKGROUP DISTRIBUTION & REPORT

	GROUP – I	GROUP – II	GROUP – III	GROUP – IV
	Equipment for site certification upto 8 weeks	Equipment for site certification upto 12 weeks	Provider training requirements	Increasing training capacity
Facilitator	Dr. Sharad Iyengar	Dr. D. K. Tank	Dr. V. K. Manchanda	Dr. Dinesh Agarwal
Rapporteur	Dr. Kuhu Maitra	Dr. Nozer Sheriar	Dr. Reva Tripathi	Ms. Poonam Arora
Members	Dr. A. Banerjee	Dr. V. K. Behal	Dr. Chandrawati	Dr. Kalpana Apte
	Ms. Teresa McInerney	Dr. Paul Blumenthal	Dr. Chandrashekhar	Dr. N. K. Biswas
	Dr. Veena Mathur	Dr. D. K. Ghorai	Dr. A. Chatterjee	Dr. Kurus Coyaji
	Dr. N. Namshum	Dr. B. Kalpagam	Dr. Kim D. Tetteh	Dr. Ravi Duggal
	Dr. Kamini Rao	Dr. Sangeeta Kaul	Ms. Karen Otsea	Mrs. R. Gujral
	Dr. Lisa Thomas	Dr. V. Pendse	Dr. Prakasamma	Dr. N. C. Saxena
	Dr. Halida H. Akther	Mr. Rajiv Sharma	Dr. Sneh Vishwanath	Mr. Don Weeden

Report of Workgroup– I

Specific issues on detailed standards of QOC only – for certification and site selection

a) Change in rules and regulations

b) Following recommendations for certification < 8 weeks

- Physical facilities
  - Space for counseling
  - Procedure
  - Recovery
  - Privacy
- Arrangements for clean water, running water preferable
- Equipment
  - MVA/EVA (Optional)
  - Gynae examination table
  - Ambubag
  - Oral Airway
  - Emergency drugs to combat cardiac arrest
  - Drugs and parental fluids for emergency use
- District level certification committee
  Public and Private / NGO
  Minimum 5 people
  - 1 person to visit the site
  - Check list for site certification required
  - Fee for certification
  - Time limit/default certification
- How should complications be managed? Specify
  - Clinical assessment
  - Stabilization
  - Referral (transport to a site or a physician to a site)
  - Treatment protocol for prescriptions will be modified depending on the provider at that site.

Report of Workgroup – II

Equipment requirements for site certification (upto 12 weeks gestation)

'Take care of the small things and the large things will take care of themselves'.

Review of topic area

- **Setting the paradigms**

  There is little difference between early abortions (upto 8 weeks) and MTP's through the full first trimester (upto 12 weeks) in clinical practice. However MTP procedures between 8 to 12 weeks may require more provider skill and experience, in view of a marginal increase in risk of complications and need a few additional adjunctive drugs and facilities.

- **Process for Site Certification**
  - Application at District Authority CMP/DHO/ Civil Surgeon Inspection by designated expert committee.
  - Recognition presumed within 90 days if not cleared / rejected.
  - Option to reapply to higher authorities.
  - Certification not linked to personnel or proximity to blood bank facilities.

- **Management of complications.**

  Identification and management as part of training protocol Facilities to manage not necessary on site?
  - Repair of local cervical trauma feasible
  - Management of haemorrhage

Equipment requirement

Surgical set for gynaecological exmination, dilatation and evacuation by VA – MVA/Electric

Dilators
Speculae
Vulsellum/tenacullum
Sponge holder
Ovum Forceps
Curette

Anaesthetic, resuscitation and sterilization equipment [MTP Rules 1975, item 4 (ii) (b)]

- No requirement for anaesthetic equipment
- No Boyles
- No O_2 supply
- No requirement for resuscitation equipment
- Sterilisation equipment
  - Decontamination
  - Disinfection
  - High Level disinfection – boil/ autoclave/chemical disinfection
  - Sterlisation of cannulae
  - Disinfection for syringes
  - Off site processing

Drugs and parenteral fluids for emergencies [MTP Rules 1975, item 4 (ii) (c)]

- Adrenaline, atropine, antihistaminics
- Uterotonics – oxytocin, methylergometrine or prostaglandins
- Antiemetics
- Intravenous fluids and infusion sets and cannulae

Facilities for MTP services upto 12 weeks

MTPs may be done in safe and hygienic conditions [MTP Rules 1975, item 4 (i)]

- Clean room
- Adequate size – not specified

Equipment required/recommended

Operation table and instruments for performing abdominal / gynaecological surgery [MTP Rules 1975, item 4 (ii) (a)]

Procedure table

Gynaecological examination / operation table allowing a lithotomy position.

Reasonable light for gynaecological examination spotlight and torch

OT light not required

Capacity to provide IV infusion

Instruments/equipment for abdominal/ gyanecological surgery not required.

Are there significant differences in the facilities required for upto 8 week or upto 12 weeks?

There being no statistically significant differences in the conduct of the procedure, time taken or complications the facilities to be established are largely comparable.

Larger cannulae

Enhanced vacuum – EVA?

Need for dilatation

Enhanced training

Level at which MTPs upto 12 weeks may be performed?

Recommend that first trimester MTPs may be performed at a Primary Health Centre or comparable facilities in the private or NGO sector.

Suitable facilities allotted to PHCs for RCH services.

Many PHCs not manned by suitable medical staff.

Patient Selection

Address as part of training protocol not certification criteria.

Previous CS

Severe medical disorders anaemia included.

Report of Workgroup – III

Consensus was very difficult

Some participants had very strong reservations.

Eventually following was agreed.

Types of Providers

For 8-12 weeks	:	status quo to continue
Upto 8 weeks	:	MVA
Doctors	:	Obs./Gyn. Specialists
	:	MBBS with house job
	:	MBBS with Gyn. Posting
	:	MBBS with Gyn. Posting - additional training
Non MBBS Doctors	:	Homeo
		ISM - Ayurvedic, Unani
Nurses	:	BSc.
	:	? Diploma
	:	? ? ANM/LHV

Training requirement

Details need to be worked out as each group has different requirements minimum :

Doctors Training

With Gyn. Posting : 10 cases – all independent

Without Gyn. Posting : 20 cases of which at least 10 to be done individually

No. may be increased if skills are inadequate.

For skills – training must be one to one – not groups.

Details of minimum standards required to be worked out.

Nurses Training - Principles

a. Extra training to be given after regular course
b. Duration of training will vary depending on existing level of knowledge.
c. Theory – Pass Exam – Clinical/Hands on
   - One to one;
   - Adequately skilled
d. Evaluation procedures must be very strict.
e. Post training monitoring of performance must be very vigilant with clients response incorporated.
f. Consider withdrawal of certification.
g. Start with a pilot project and possibly start with Inc. Ab.
h. MTP by nurses under qualified physician.
i. Trainers must be made aware of the magnitude of their responsibility before certifying.

Provider Certification

1. Faculty of medical colleges (Ob/Gyne.)
2. Specialist – UPSC, Distt. Hospitals
3. Doctors of NGOs

   PP – who?
   - Spread base of trainers – training of trainers
   - No. of training centers
     - all medical Colleges
     - all District Hospitals

   Repeated evaluation

Policy change - Some Recommendations

1. Obs/Gyn. Training essential prior to PHC posting (3-4 months)
2. Those doctors who do rural posting get preference for PG seats
3. Counselling and communication skills must be included in medical colleges curriculum
4. Provision of counsellor in every FP clinic - ? use ANMS

Report of Workgroup – IV

Increasing Training Capacity (Including training centre certification requirement)

1. Training center certification requirements – upto 12 weeks
   - Any center performing a minimum of 500 abortions in a year
   - Presence of designated trainer at the center who should be either an Obs. And Gyne. Specialist or an MBBS doctor with at least 3 years experience in conducting MTPs
   - Trainer should have undergone standardized TOT at the state level

2. Increasing MTP training capacities throughout the country.
   - Increase the No. of training sites by involving
     - District Hospitals
     - Urban Hospitals
     - FRUs
     - CHCs
     - NGOs/Private sector facilities

- Central Government to evolve strategic plans to include National NGOs in this process of imparting training.
- Improve the capacity of existing and new sites by addressing administrative constraints.

3. Guidelines for involvement and approval of NGOs.
   - NGOs to be incentivised enough for sustaining their interests in imparting training to Government/Private sector providers
   - The standard fee per trainee should be regulated and subjective to periodic revision.
   - District Health Official (DHO) to grant approval for training sites.

4. Process for site approval

Certification process would include steps like application inspection for initial certification for 5 years.

Renewal would be based on the basis of monitoring and evaluation.

INAUGURAL ADDRESS

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Secretary (Family Welfare),
Ministry of Health & Family Welfare (MOH&FW)
Government of India,

INAUGURAL SPEECH DELIVERED AT THE NATIONAL CONFERENCE ON 'MAKING EARLY ABORTION SAFE AND ACCESSIBLE"
Agra, 11-13th October, 2000

Abortion is a significant medical and social problem worldwide. While the need for aborting an unwanted pregnancy may arise due to variety of reasons, it is the social, religious, cultural and ethical beliefs and sanctions attached to it and also lack of appropriate facilities that have led to women taking recourse to unsafe methods of seeking abortions either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both. WHO estimates that about 20 million unsafe abortions take place globally every year, most of these in developing countries. Whether spontaneous or induced, abortion has been a matter of concern particularly because of sepsis and other complications that lead to maternal morbidity and mortality.

Unsafe abortion is a major cause of maternal mortality in India. According to data available from the Registrar General of India, unsafe abortions account for more than 7% of maternal deaths each year. Reliable data on the extent of unsafe abortions in India is not available. However, various studies including the one done by the Indian Council of Medical Research in 1989, show that of every 1000 pregnancies about 13.5 result in unsafe abortions.

India was one of the first countries to enact a legislation, providing termination of pregnancy through the Medical Termination of Pregnancy Act in 1971. The aim of this Act was to eliminate illegal and unsafe abortions by untrained persons under unhygienic and unsafe conditions by improving the accessibility and availability of scientifically approved services in order to reduce maternal mortality and morbidity. Besides medical reasons, the Act also provides for termination of pregnancies on broad social grounds like rape and unwanted pregnancies resulting from failure of contraceptives.

The MTP Act specifies the gestation age upto which MTP can be done, the place where termination of pregnancy can be undertaken and the qualifications, experience and training of personnel who can conduct the termination of pregnancy, conditions for approving the place for medical termination of pregnancy and various reporting/recording procedures for the termination of pregnancy.

Over the years, the number of recognised centres providing MTP services has gone up and presently more than 9000 recognised centres are providing these services. Most of these centres, however, are located in urban or semi-urban areas. This is one of the major reasons why despite abortions having been legalised in 1971, unsafe abortion is still one of the major causes of high maternal mortality in the country. Govt. of India is now trying to make safe abortion services available and accessible to women in rural and other areas under the RCH Programme. This is being done through a series of strategic changes in programme.

Government is in the process of amending the MTP Act, seeking to delegate the powers and responsibilities to the district level, specifically powers for recognizing private hospitals and clinics for MTPs. The other provision that is being amended is the incorporation of certain punitive provisions for clinics and untrained providers doing unsafe abortions.

In the Reproductive and Child Health Programme, special provisions have been made for improving access to the service in rural areas. Provision has been kept for equipment and training of doctors working in primary health centres and also for the

clinics and hospitals in the private sector. Involvement of the private sector by facilitating training and providing equipment is the major strategic input in the programme. The programme also provides for engaging doctors from private sectors to make periodic visits to the rural health centres. Drugs in adequate quantities are also being made available.

Indian women seek abortion throughout the reproductive period. Adolescents, both married and unmarried seek abortion services in significant numbers. As adolescents have less access to reproductive health information and services compared to older married counterparts, they are more likely to seek care from unsafe providers. India's second trimester abortion rate, that is, those with 12 to 20 weeks of gestation, is thought to be among the highest in the world. It is estimated that over 10% of all abortions in India are second trimester abortions. Women in the second trimester are more likely to access illegal providers, as it is difficult to obtain legally. The risk of complications following second trimester abortion is much higher for physiological reasons.

Our Government is committed to bring down the maternal mortality rate to less than 100 by the year 2010 with this in view, it is essential that access to safe abortions is improved particularly in the rural and remote areas by using all available and safe methods of providing safe abortion services. The National Population Policy has already made out a strong plea for use of the MVA on manual techniques by trained para medicals or middle level providers.

I have been informed that the issues of improving access to abortion services by adopting alternate strategies were discussed at a recent consultation organised by WHO in Geneva. The meeting provided the representatives of my Department with an opportunity to get acquainted with the policies and practices of other countries using different methods of abortion. It will be of interest to us to know more about the experience of Bangladesh where wide scale use of the MVA technique through trained midwives is being undertaken. The extent to which the unsafe abortions have come down and as a consequence the reduction in incidence of septic abortion as cause of maternal mortality will, I hope, be discussed during this meeting. I understand that the experience of other countries like South Africa where MVA technique is being used through trained midwives will also be discussed in detail during the deliberations of this meeting. Of special interest to us will be the experience of these countries regarding the training inputs required by mid-level providers who practice MVA.

The issues to be discussed in this meeting are of particular relevance, as bringing in any mid level provider will require amending the existing MTP Act, which allows only qualified doctors to perform MTPs. This will require much larger consultations and consensus among experts and various associations and other stakeholders. We hope to follow up this meeting with a national consultation of experts to deliberate on the various issues raised in this meeting. It is in this context that I hope that the presentations, workgroups and discussion during the meeting will result in recommendations which will help us in taking decisions for making early abortion safe and accessible to all women in every corner of the country and thereby help in achieving the goal of reducing maternal mortality and improving the health of Indian women.

CURRENT SITUATION OF ABORTION IN INDIA

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KEYNOTE SPEECH DELIVERED AT THE NATIONAL CONFERENCE ON MAKING EARLY ABORTION SAFE AND ACCESSIBLE,
Agra, October 11-13, 2000

CURRENT SITUATION OF ABORTION IN INDIA

ACKNOWLEDGEMENT

The author gratefully acknowledges the assistance provided by Dr. Kuhu Maitra, Project Director, Population Council, India, in preparing this paper.

Introduction

Consequences of unsafe abortion are a serious public health problem in India. There are 437 deaths per 100,000 live births from causes related to pregnancy and childbirth. (International Institute of Population Sciences, 1995). Many more women suffer from chronic and life-threatening complications (Fortney et al, 1996). On an average, 15% of maternal deaths are due to unsafe abortion (Registrar General, 1995) which also results in morbidity, chronic disability and sterility. Although unsafe induced abortion is a major cause of mortality for women, it is also the most preventable. Women need not die or suffer medical consequences from abortions because abortions do not kill women; it is unsafely performed abortions which kill (Maine, 1991). A key issue is why do women resort to unsafe methods to terminate unwanted pregnancy when abortion is legal in India?

This paper aims to focus attention on the following three key questions:

1. What was the legal framework for liberalizing abortion when the Medical Termination of Pregnancy (MTP) Act was passed in 1971 and how has the context changed?

2. Why has legalization of abortion failed to provide access to safe abortion services for women in India?

3. What can be done to enhance access to safe abortion care within the current policy environment?

1. What was the legal framework for liberalizing abortion when the Medical Termination of Pregnancy (MTP) Act was passed in 1971 and how has the context changed?

The need for liberalizing abortion in India first came under public debate in early 1960s that led to a 1966 congressional committee — the Shanti Lal Shah Committee — submitting a positive report to the government on the need to liberalize the abortion law. This was followed by five more years of debate and review of regulatory options until the MTP Act was brought before the Parliament in 1971 and was unanimously adopted by all political parties.

The MTP Act of 1971 permits the termination of pregnancy in the following two cases:

1. where continuance of the pregnancy would involve a risk to the life of the pregnant woman or grave injury to her physical or mental health; and

2. where substantial risk exists of the child being born with serious physical or mental abnormality.

The MTP Act goes on to state that pregnancy due to the failure of contraceptive methods could also be aborted as the "anguish caused by such unwanted pregnancy may be presumed to contribute a grave injury to the medical health of the pregnant woman".

The changes in regulatory controls on abortion were initially the outcome of concerns within the medical community about high maternal mortality. The MTP Act, piloted through with the strong backing of the medical lobby, also carried a strong medical bias: its twin objectives were liberalisation of the grounds on which abortion could be possible and strict controls for the conduct of the procedure only by legally recognised, skilled medical practioners. Thus, it simultaneously decriminalised and medicalised abortion. Both steps were conceived at the time, without doubt, in the most enlightened interest of women's well being. The law also provided safeguards for the medical practitioner who undertakes to perform the procedure according to rules and regulations stipulated within the law (Chhabra and Nuna, 1994).

Subsequently, the provision of MTP services was influenced by broader forces in the socio-political environment including the use of targets and incentives that sought to reduce birth rates. The combination of regulatory preconditions and societal influences on the MTP Act has had a major impact on the provision of abortion services in India. Over the years, the ideology of control and dominance as well as strong presence of medical barriers have continued to govern many aspects of MTP service delivery.

The law, although conceptualised in the best interest of women with the leadership and support of the medical profession, visualised a far too idealistic health care system than India has been able to organise in subsequent years. The rules and regulations drawn up in detail to safeguard the woman have also served to strangulate growth of services (Chhabra and Nuna, 1994). Although thought to be a landmark in social legislation, the MTP Act has failed to translate into reality for the majority of Indian women, particularly in rural areas.

Despite a liberal law, there continue to be many more abortions outside the legal stream than within it. An estimated 85% of the approximately 6.7 million abortions conducted annually in India are performed outside the law. Many of these are unsafe. Three decades later, there are more abortion deaths in India than there were prior to the MTP Act with some 15,000–20,000 abortion-related deaths occurring annually among married, multiparious women (Chhabra and Nuna, 1994). Thousands more women are impaired permanently by complications that are the outcome of unsafe abortion. Clearly, abortion services as currently implemented, are not addressing women's reproductive health needs.

It is important to bear in mind that when the MTP Act was passed some three decades ago, the legal context of the Act was not an expression of the government's recognition of women's rights to control their own sexuality, fertility and reproduction (Huntington et al, 2000). The context for the delivery of reproductive health services for women has changed significantly over the past two decades. Prevention and management of unwanted

pregnancy is a key intervention within the current provision of reproductive health services. Abortion is a proxy indicator of unmet need for family planning. The conceptual link between family planning and abortion is fundamental. Effective contraception is an important means to prevent unwanted pregnancy and pre-empt the need for abortion, but in the absence of safe abortion back up, women are forced to employ unsafe means to terminate unwanted pregnancies with attendant high maternal mortality and morbidity (Pachauri, 1993).

Expanding family planning services is an important strategy for decreasing pregnancy related mortality and morbidity. Estimates show that if all women who state that they want no more children were able to avoid future pregnancies, there would be a substantial decline in maternal mortality (Maine et al, 1987). However, even with vigorous family planning programmes, there will always be some unwanted pregnancies, and therefore, a demand for abortion. High levels of maternal mortality associated with clandestine, unsafe abortions can be prevented by enhancing women's access to safe abortion services.

The National Population Policy articulates the need for providing quality reproductive health services to address clients' needs (Government of India, 2000). The essential elements of quality, including technical competence of service providers; client-provider interaction through gender-sensitive counselling; and instituting mechanisms to ensure continuity of care, are essential for providing safe abortion services within a reproductive health approach.

In the next section, while the discussion is focussed primarily on access to safe abortion care, it should be noted that access is related to the quality — especially quality as perceived by the users of services. Therefore, to enhance access to safe abortion services, it is important to ensure service quality and standards of care.

2. Why has legalization of abortion failed to provide access to safe abortion services for women in India?

Although very liberal in its mandate, the MTP Act includes several restrictions which have been counterproductive in making abortion services widely and easily accessible to women.

- First, abortion procedures can only be performed by doctors who have received training in MTP. For pregnancies up to 12 weeks, the certification of one qualified doctor is sufficient but for pregnancies between 12 and 20 weeks, two doctors must give their approval.

- Second, abortion cannot be performed in any place other than a clinic or a hospital established, or maintained by the government, or an institution approved by the government for this purpose.
- Third, certification procedures for facilities and service providers are cumbersome and bureaucratic and are currently the same for all gestations upto 20 weeks. Pregnancy termination in the second trimester is a more difficult procedure requiring greater skills However, the majority of abortions are performed in the first trimester. There is a need to make a

clear distinction between early and late pregnancy termination as training skills, equipment needs and facilities required are different for first and second trimester abortion.

These restrictions that relate to **who** can provide abortion services and **where** these can be provided, have become major obstacles to making services accessible, especially for poor women.

What are the obstacles women face in accessing safe abortion services?

Access to services is problematic because of several physical, economic and social constraints that women face. The causes and consequences of these constraints are discussed here under:

PHYSICAL ACCESS

Within the public health care system, legal/safe services are concentrated at the tertiary level/urban centres while over 60% of all abortions occur in rural areas. Relatively few legal/safe services are available at the primary care level. It is estimated that only 14% to 18% of all primary health centres (PHCs) and community health centres (CHCs) actually provide abortion services (Khan et al, 1999). In the private sector, most legal practitioners are specialist doctors who operate primarily in urban areas.

After the introduction of the MTP Act, the number of approved institutions providing MTP services increased from 1,877 in 1976 to 8,511 in 1994-95. In parallel, the number of reported MTP cases also increased from a mere 25 in 1972-73 to over 600,000 in 1994-95. After a rise in the numbers of reported abortions upto 1985, the number has remained stationary at around 600,000. This represents a small fraction of the actual number of abortions performed in India. The fact is that there are no valid data for the country. It is estimated that, every year, an additional five to six million abortions are conducted at unrecognised facilities by practitioners who may be qualified or unqualified. As these abortions by definition are illegal, they are not reported in any statistics. Most of these are unsafe abortions conducted by unqualified providers who include a large heterogeneous group.

Although the number of government approved facilities has increased to 9,467 in 1997, the need is much greater. These facilities are unequally distributed within states which further compounds the problem. There are more approved facilities in the more developed states, which have smaller populations. For example, in 1995, a more developed state like Maharashtra, with about 10% of India's population, had 1,808 abortion facilities, constituting 21% of the total number of all registered facilities in the country. In contrast, less developed Bihar, also with about 10% of India's population, had 1% of the total number of facilities. Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, the four least developed states, that account for about 40% of the country's population, had less than 17% all approved abortion facilities (Khan et al, 1999).

Another anomaly is that many of the approved facilities are not functioning. Since available records at the state and district level do not provide adequate information, a situational analysis was undertaken by the Centre for Operations Research in four states — Gujarat, Maharashtra, Uttar Pradesh and Tamil

Nadu — to provide the answer to this important question. A total of 61 districts, 510 approved institutions and 241 private health practitioners were studied. Only about one-fourth of the PHCs in Maharasthra (27%) and Uttar Pradesh (24%), one-third in Gujarat (32%) and more than one-half (58%) in Tamil Nadu were currently providing officially approved services (Khan et al, 1999).

An analysis of why MTP services were not provided showed that 70 to 92% of the centres had no trained doctor. The lack of trained doctors and the non-availability of equipment were identified as two main reasons for not providing abortion services at government approved clinics. There was a substantial mismatch between the availability of approved facilities, trained providers and necessary equipment. Where facilities existed, there were no trained providers and/or equipment and vice versa. Only 10% of registered clinics certified to perform MTP had both a trained provider and equipment (Khan et al, 1999). Even worse a substantial proportion of the approved PHCs (24 to 40%) that had been providing MTP services in the past, were not doing so currently. Among these centres 16-52% after having been approved, had never ever offered MTP services. (Khan et al, 1998).

Contrary to expectation, after the liberalisation of abortion, there has been no systematic effort by the government to train doctors to provide MTP services. Estimates in 1992 indicate that only about 3,000 trained doctors were available compared to the approximately 21,000 required to serve all primary health centres, in the rural areas (Chhabra and Nuna, 1994). There are only about 160 certified training centres in the country. A more recent study showed that for a variety of reasons in most of the designated training institutions, the number of doctors trained in a year (6-10) was less than the training capacity of these centres (Khan et al, 1999).

Thus, in the public sector there are inadequate numbers of approved facilities. These facilities are unequally distributed and many are non-functional because of a shortage of trained providers and equipment.

ECONOMIC ACCESS

Government services are theoretically free. However, it is well known that clients pay for MTP services placing a barrier to women's access to the public health care system (Khan et al, 1999). The cost of travelling to institutions where safe abortion services are available is high, both in time and money. The cost of abortion in the private sector is also high. NGOs providing quality care at low cost are few in number.

Equipment mandated in the public sector is more medicalized than is necessary for peripheral level, rural facilities that provide services for terminating first trimester abortion. Currently, it is mandatory for all approved centres to have sophisticated equipment needed for second trimester abortion. Costs can be saved if the requirements for equipment are rationalized by making a distinction between equipment and staff needs for early and late abortion.

Funding of the government programme has also been a constraint. Since 1991-92, approximately US$ 350,000 has been allocated for the national

MTP programme annually. In 1995-96, influenced by ICPD recommendations, a serious effort was made to strengthen services and increase the number of MTP centres and an amount of about US$ 2.3 million was requested. However, referring to financial constraints, only about US$ 350,000 were allocated for this programme. (Khan et al, 1999).

SOCIAL ACCESS

Several studies have underscored the problem of the social distance between providers and users of services. First, awareness about the legality of abortion is serious lacking. Even today, many people are not aware that abortion is legally approved by the government. For example, a study by the Indian Council of Medical Research in 1989 showed that only 31% of women in Tamil Nadu and 75% in Uttar Pradesh and Haryana believed that abortion was illegal (ICMR, 1989). A more recent study in 1996 showed that 72% of the people in Bihar thought abortion was illegal (CORT 1996).

Another social barrier is that abortion is a moral and emotive issue for both providers and users of services. The following quotes exemplify the ambivalence of both:

A rural woman who was interviewed in Uttar Pradesh stated,

"I am not at all in favour of abortion. I never consider it good. After all the foetus is growing in the stomach — there is a life in that. Killing of any life is a sin."

Another woman said:

Abortion is a big sin (mahapap). — If I am not able to give life then I do not have any right to destroy life —— supposing somebody gets rid of this pregnancy then she might not be having a chance to see the face of a child in her next life (rebirth)."

A trained lady doctor performing MTPs stated:

"As a human being I will also say that it is not good but I am doing it because it is my profession."

Another PHC staff member said:

"I think, being an Indian, nobody will be in favour of abortion from within — we are doing it because it is our duty. We have to bring cases for sterilization, so if anybody is ready for sterilization after abortion, then we cannot leave the case."

Thus, women fear hostile reactions and forced contraceptive services as a pre-condition for the provision of MTP services from public sector providers (Sinha et al, 1998).

Confidentiality is a real issue for all clients but especially for adolescents and unmarried women (Jejeebhoy, 1998; Parivar Seva Sanstha, 1998). Women who have a critical need for confidentiality for fear of social stigmatisation to terminate an extramarital pregnancy are more likely go to the private sector. They are also more likely to delay seeking MTP services and resort to illegal providers thus facing greater risk associated with second trimester abortion (Khan et al, 1999; Barge et al, 1997; Keriggan et al, 1995 and Ravindran, 1994).

Women who have the choice between public and private providers report feeling more satisfied with

the services of private providers. Care at the public government PHC is reportedly inadequate. PHCs do not maintain client confidentiality; care is expensive; and PHCs tend to be far from where women live and thus difficult to access.

Trained private sector providers are often not certified because certification is cumbersome and bureaucratic. By not registering, they can avoid the extensive paperwork associated with registration, which can take as long as five years and also avoid paying tax. The fact is that illegal providers are rarely prosecuted.

Of the approximately 40,000 trained doctors, 80% are practicing in urban areas. Because of the barriers preventing women, especially poor rural women, from accessing legal abortion, they seek services from unregistered, illegal providers. Abortion services from unregistered providers range from completely safe — by trained medical doctors in appropriate facilities — to life- threatening — by a range of providers in various settings. Illegal abortion providers include trained medical doctors and nurses in hospitals, indigenous medical practioners, auxillary nurse midwives, ayurvedics, homeopaths, traditional birth attendants, pharmacy shopkeepers, and village women. These providers use a variety of oral and vaginal methods to induce abortion.*

Because of all these physical, economic and social barriers there is a huge gap between demand and supply of MTP services. Government statistics reflect only those induced abortions that are carried out in officially recognized facilities. Unofficial estimates range widely from 3.9 to 6.7 million. While it is difficult to arrive at a conclusive figure, the overall picture is clear. The total number of abortions conducted in India every year is about eight to ten times higher than the officially reported service statistics. Even if it is assumed that 10-20% of the illegal abortions are performed under safe and hygienic conditions at private clinics and nursing homes, it still means that up to 80% of all abortions are conducted by untrained providers who use unsafe methods.

Given the relatively poor availability of MTP services, it is not so surprising that a majority of women resort to private clinics; go to untrained practitioners; or employ various traditional methods themselves. Consequently, large numbers of women are exposed to the risk of post-abortion complications and death, essentially as a result of an unmet need for safe abortion services.

In summary, a review of literature shows that a great deal is known about the problem of access to safe abortion services in India. There is ample evidence that signifies an urgent need to improve services delivery. The current policy environment is also most favourable for initiating action to overcome barriers in service provision. Several steps can be initiated immediately to save women's lives lost due to unsafe abortion (Johnston, 1999).

3. What can be done to enhance access to safe abortion care within the current policy environment?

International consensus on reproductive rights provides a strong rationale for reproductive choice. This has significant relevance for enhancing access to safe abortion services, especially in countries such as India where abortion is legal. The National

Population Policy and the Reproductive and Child Health Programme provide an exceptionally enabling environment in India to implement services to address clients' needs.

The National Population Policy has, infact, provided a comprehensive strategic framework to enhance access and improve quality of reproductive health services. It advocates the provision of safe abortion care within an integrated package of reproductive and child health services. The following are some key recommendations to remove barriers and enhance access to MTP services in India:

1. ***Promote Community Education***
   Community campaigns should target women, household decision-makers, and adolescents about the availability of safe abortion services, and the dangers of unsafe abortion. Men too should be involved as they are important decision-makers.

2. ***Enhance Service Utilization***
   Safe and legal abortion services should be made more accessable by: (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality; and (iv) providing compassionate abortion care, including post-abortion counselling.

3. ***Expand Provision of Services in Public Sector***
   Services must be able to meet the demand for termination of pregnancy at primary health centres and at community health centres. Considerable expansion is needed if demand has to be met.

4. ***Simplify Procedures for Certification***
   Current cumbersome procedures for registration of abortion clinics and practioners should be simplified. Procedures for the registering MTP training centres in the public, private, and NGO sectors should also be simplified to increase the geographic spread of facilities and numbers of trained providers.

5. ***Adopt Updated and Simple Technologies that are Safe and Easy***
   Methods such as manual vacuum extraction, that are not necessarily dependent upon anaesthesia, and non-surgical techniques which are non-invasive should be made available.

6. ***Provide Post-abortion Care***
   Competent post-abortion care should include management of complications; identification of other health needs including contraceptives needs of clients; and developing linkages with appropriate services to meet those needs.

7. ***Ensure Standards for Service Quality***
   Quality of services must be monitored to maintain standards of care in both the public and private sectors.

8. ***Institutionalize Quality Training Programmes***
   Curricula for medical graduates should be modified to incorporate abortion care. Continuing education and practical in-service training for new procedures should be ongoing to upgrade providers' skills.

9. *Enhance Public and Private Sector Collaboration*

Linkages should be forged between all stakeholders to enhance access to safe abortion services for women.

10. *Promote Monitoring and Research*

Data on MTPs should be generated on an ongoing basis for planning and monitoring the programme. Operations research is necessary to assess the feasibility, cost and effectiveness of programmes.

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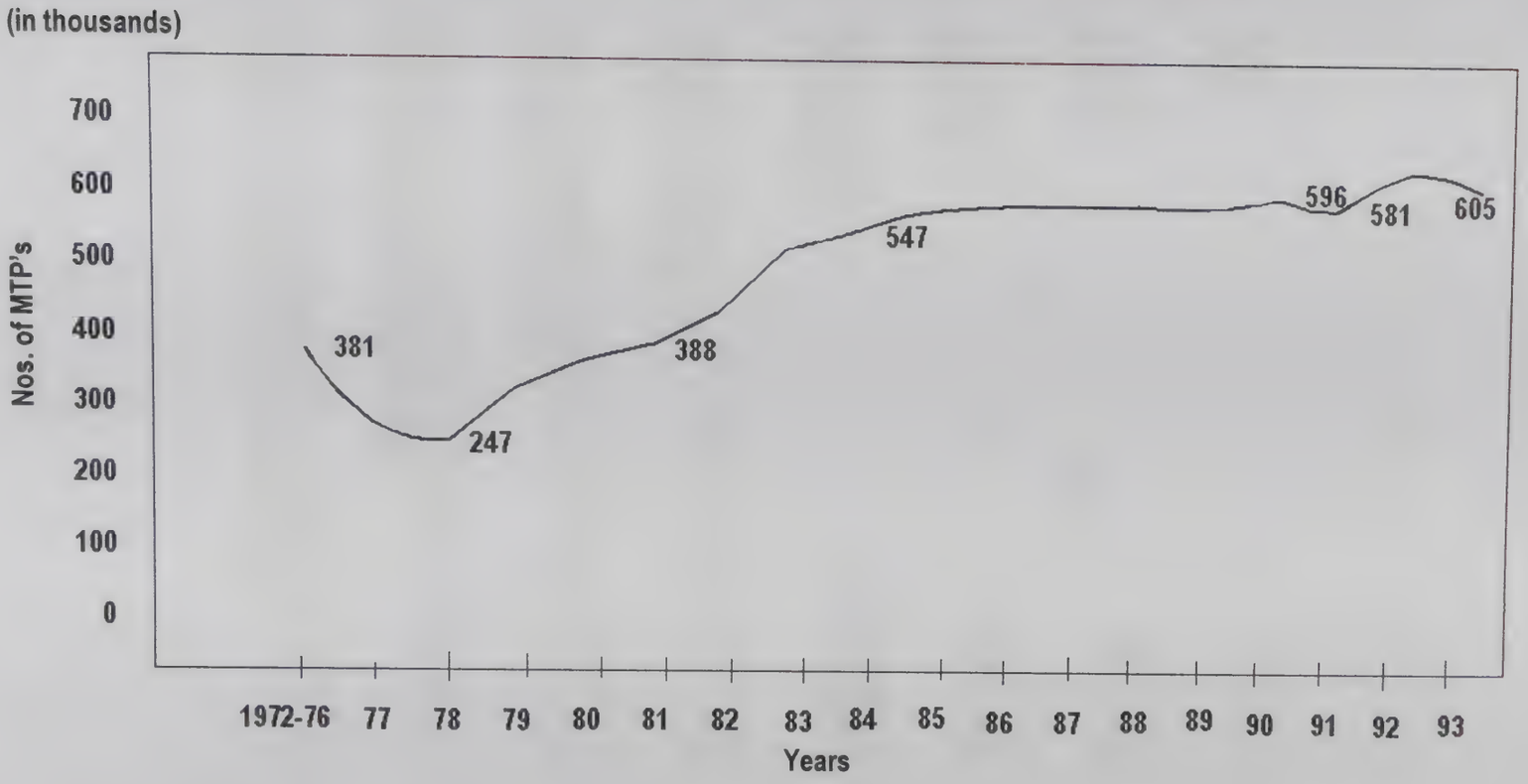
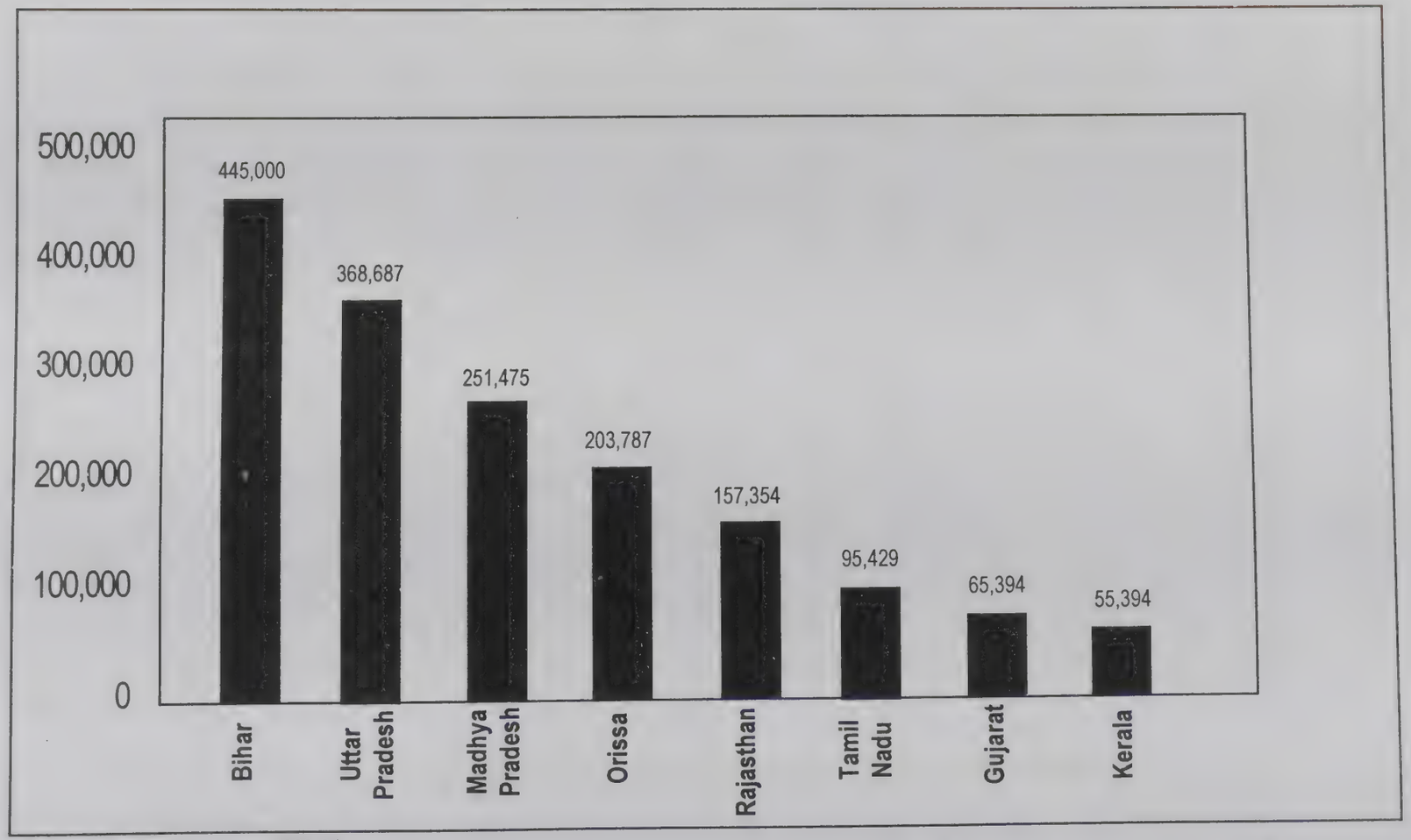
TREND OF REPORTED MTP IN INDIA



Source: Department of Health & Family Welfare, Government of India, 1998

Population Council

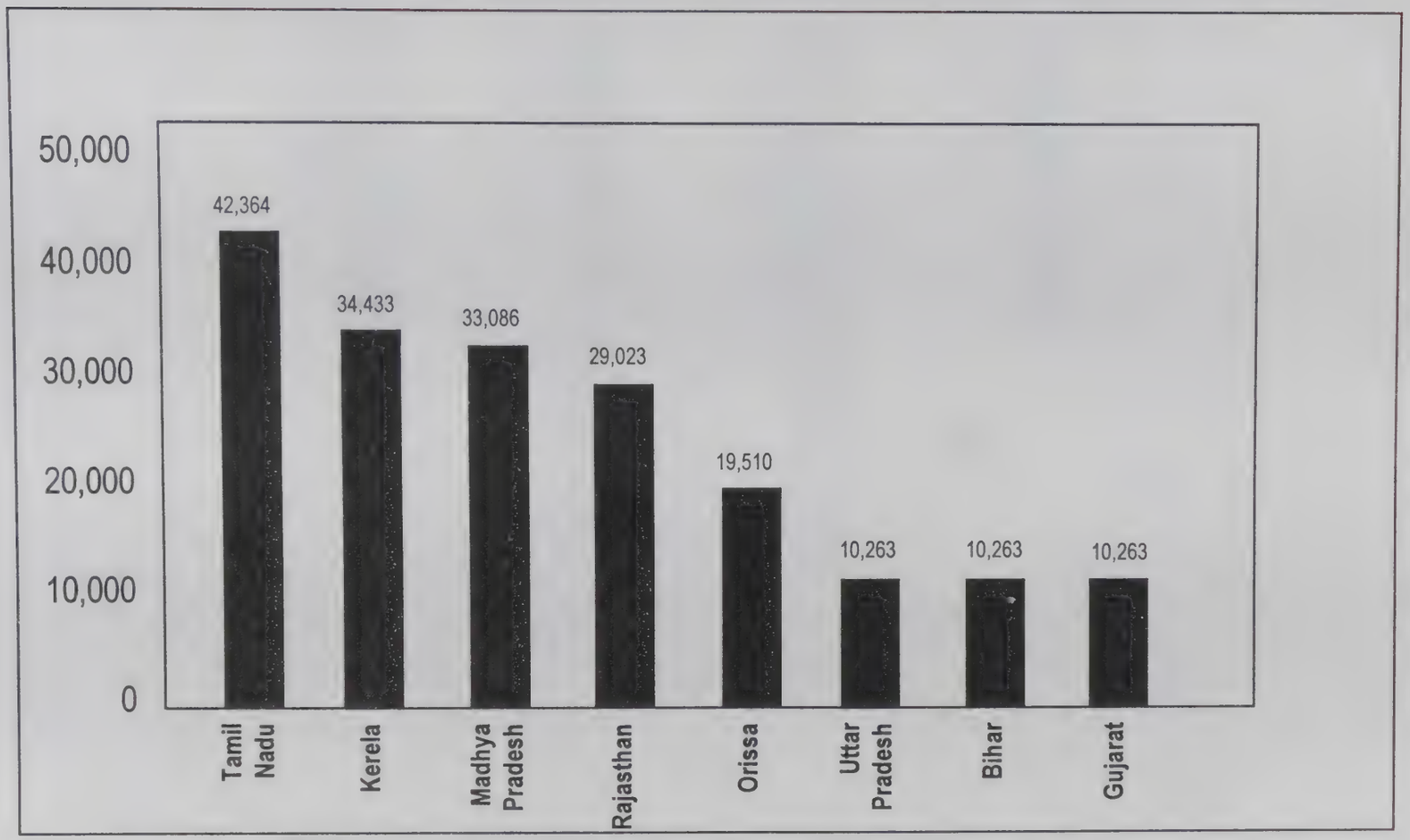
POPULATION: INSTITUTE RATIO BY STATE, 1993-94



Source : Government of India, 1993-94

Population Council

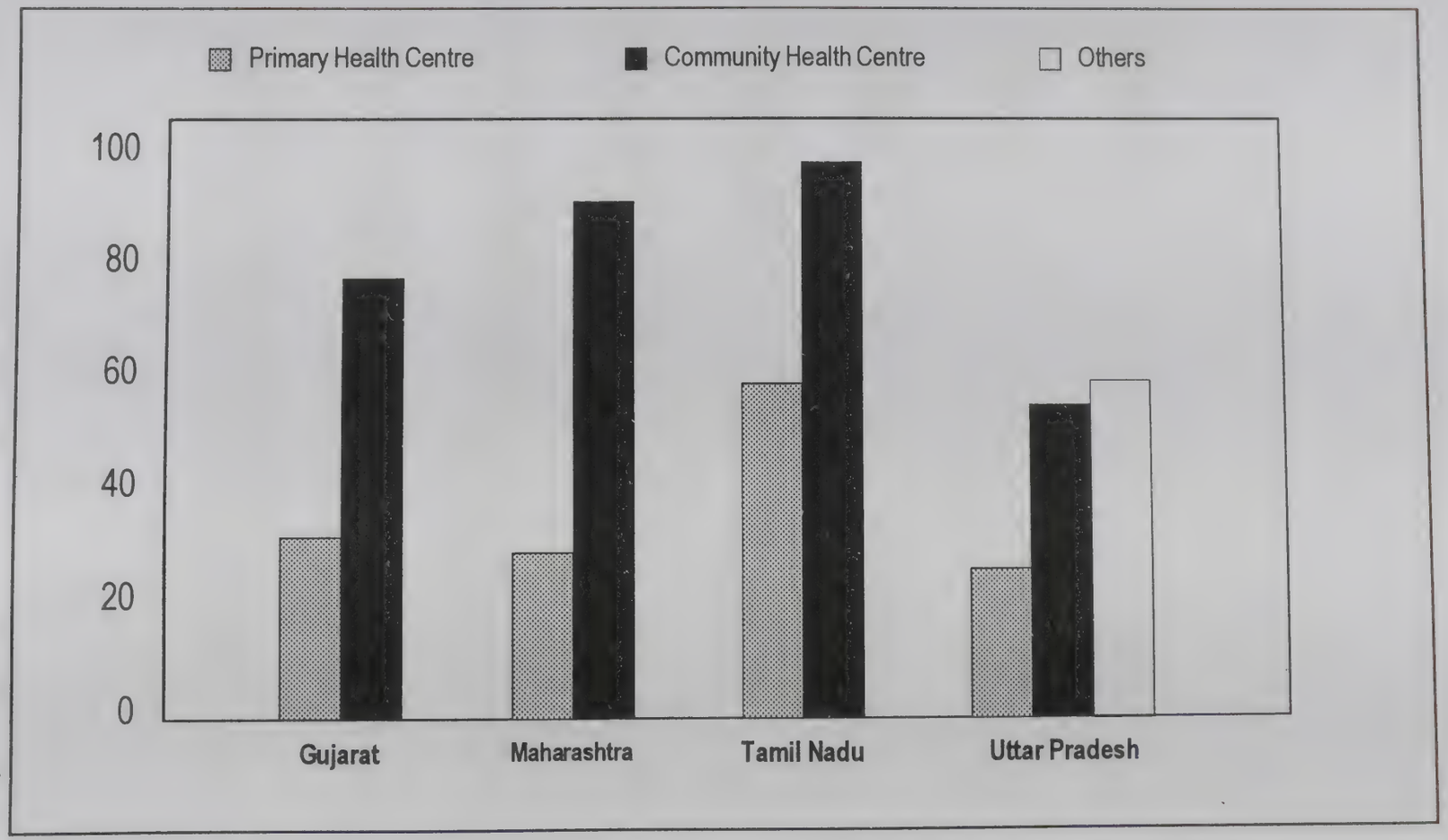
NUMBER OF MTPs IN STATES, 1993-94



Source : Government of India, 1993-94

Population Council

AVAILIBILITY OF MTP SERVICES AT GOVERNMENT CLINICS



Source : Khan, et al, 1999

Population Council

MANUAL VACUUM ASPIRATION DECENTRALISING EARLY ABORTION SERVICES

Dr. Nozer K. Sheriar
MD, MICOD, DNBE, FCPS, DGO
Chairperson, MTP Committee
Federation of Obstetric & Gynaecological Societies of India
Member, Medical Advisory Panel
Family Planning Association of India

PRESENTATION AT THE NATIONAL CONFERENCE ON MAKING EARLY ABORTION SAFE AND ACCESSIBLE, Agra, October 11-13, 2000

Unsafe Abortion
A Life Threatening Burden

- *About 20 million unsafe abortion take place annually, resulting in close to 80,000 deaths and 100,000 disabilities*

- *A fifth of this burden is borne by India*

Meenakshi Datta Ghosh, Crossroads at the Millenium, 2000

Late Abortion Practice in an Indian Teaching Hospital

- Second trimester abortions 2055
- Represented 15% of abortions over 10 years
- Overall complication rate 11&

13-14 weeks	6.9%
15-16 weeks	12.1%
17-20 weeks	12.4%

Bhathena, Sheriar & Guillebaud, J Obs. Gyn., 10(4) : 299, 1990

MTP Provision

Inadequate & Inequitable Distribution

- *Estimated 6.7 million induced abortions annually*
  Reported MTPs (1998-99) – 613,879

- *Maharashtra, UP and TN account for 45% MTPs*

- *Rural services minimal*

Less than 1800 of over 20,000 PHCs provide MTPs
Placement of trained physicians not matched with requisite equipment

Chhabra & Nuns, Abortion in India – An Overview

Current Regulations – Rationale

- *Encompass all possible abortion techniques*

- *Apply to all gestational ages right through the second trimester*

- *Onsite care of all potential complications' availability of blood bank with 5 kms required for second trimester MTP in Maharashtra*

- *None of the rural and only 56.5% urban institutions fulfilled this requirement*

Cehat, State Level Consultation, 1999

MTP Act 1971

4. Place where pregnancy may be terminated
(a) Hospital established or maintained by Government
(b) Place approved for the purpose of this act
6. Central Govt. by notification has the power to make rules

MTP Rules 1975

5. No place approved under 4 (b) unless
i) Government is satisfied with safe & hygiene conditions
ii) Unless following facilities are provided
(a) OT for abdominal & gynaecological surgery
(b) Anaesthetic, resuscitation & sterilization equipment
(c) Drugs & fluids for emergency use

Major Complications of VA

	EA (210,164)	MVA (12,888)
♦ Excess bleeding	0.05-4.9	0.4
♦ Pelvic infection	0.1-2.2	0.01
♦ Cervical injury	0.01-1.6	0.02
♦ Uterine perforation	0.02-0.7	0.02

Cates & Grimes, 1981 Laufe, 1977

None of these complications demand emergency management

Choosing Between Surgical & Medical Abortions

- *Choice offered to 405 patients <46 days gestation*
- *Only 26% opted for medical abortion*
- *Reasons cited*
  - *Fear of experimental medications*
  - *Lack of emotional support*
  - *Avoidance of extra visits and blood tests*

Weibe, Contraception, 55-67, 1997

MVA For Incomplete Abortions Review of 4 studies (1985-1993)

♦ *Total no.*	*1413*
♦ *Gestational age*	*≤ 12 to ≤ 18 weeks*
♦ *Mean time*	*2 to 7 mins*
♦ *Effectiveness*	*98 to 100%*
♦ *Complications*	*0.3 to 9%*
♦ *Mean*	*5.6%*
	(Curettage 14.8%)

PATH, Outlook 12:1, 1994

Manual Vacuum Aspiration India's Special Needs

- *Low tech rural*
  - *Limited access to medical facilities*
  - *Non availability of reliable equipment*
  - *Poor maintenance of available resources*
  - *Erratic electricity supply*

- *High tech urban*
  - *Sensitive urine pregnancy tests*
  - *Serum* b *hCG*
  - *Transvaginal ultrasound*
  - *Appreciation of minimally invasive concept*

MVA – Essential Basic Procedure

- MVA considered an essential basic procedure at the first referral unit level

WHO, Complications of Abortions, 1995

- Outpatient MVA under LA increases access, shortens wait, reduces complication risk and cost, facilitates links between emergency and FP services.

Population Report, L (10), 1998

Safe Abortion Earlier the Better

Four fold rise in complications with late abortions
WHO, TECH REPORT, 1997

Effectiveness of Vacuum Aspiration

	Studies	Patients	Effectiveness
Induced abortion	46	4,00,000 (MVA : > 15,000)	98%
Incomplete abortion	19	5000 (MVA : > 1400)	98%

Greensdale et al, MVA, IPAS 1993

Complications Metaanalysis of 13 studies

Complications	Vacuum Aspiration (95136)	Curettage (17166)
Blood loss	0-15.7	0.5-28
Pelvic infection	0.2-5.4	0.7-6
Cervical injury	0-3.1	0.3-6.4
Perforation	0-0.5	0-3.3

Greensdale et al, MVA, IPAS 1993

Mifepristone and Misoprostol Practical Pointers

- *Optimum duration : 7 weeks (49 days)*
- *Effectiveness : 95-97%*
- *Administration : Over 2 clinic visits*
- *Failed procedure : MVA/Vacuum aspiration*
- *Side effects : Nausea, diarrhoea, cramping, hot flushes, vomiting, excess bleeding, fatigue*

MTPs in Clinical Practice A FOGSI Questionnaire

Estimated number of MTPs performed by individual practitioners each month

- *Less than 10 29.3%*
- *11-20 34.5%*
- *21-50 26.7%*
- *Over 50 9.5%*

MTPs in Clinical Practice A FOGSI Questionnaire

Percentage of MTPs in the first trimester Performed by individual practitioners

- *Over 90% 55.8%*
- *80-90% 19.0%*
- *70-80% 12.0%*
- *60-70% 6.0%*
- *50-60% 6.0%*

MTPs in Clinical Practice
A FOGSI Questionnaire

Place where MTP was performed

- *Private hospital* *92.2%*
- *Trust hospital* *4.3%*
- *Government hospital*

Registration status *3.5%*

- *Recognised center* *50%*

Sheriar, FOGSI MTP Cimmittee, 1999

MTPs in Clinical Practice
A FOGSI Questionnaire

Directed inquiry evaluating registration process

Responses from 118 centres in 16 states

- *Recognition easy* *28.8%*
- *Recognized after delay (from 1 to 7 yrs)* *12.7%*
- *Formalities complete yet not recognized* *44.1%*
- *Not aware of need for recognition* *11.9%*

Sheriar, FOGSI MTP Cimmittee, 1999

Propagating Early Abortion Services - The Way Ahead

- *Recognize simpler and safe techniques within MTP rules and regulations*
- *Standardize basic service and training to include management of potential complications*
- *Streamline facility and provider certification for private and voluntary sectors*
- *Involve and work with NGOs to extend safe, cost effective and decentralized services*

Propagating Early Abortion Services - The Way Ahead

Expand the availability of safe abortion care

- *Community level education about availability*
- *Increase geographic spread and enhance affordability*
- *Adopt updated safe, easy & simple technologies such as MVA or non-surgical techniques*
- *Eliminate cumbersome registration*
- *Established additional training centers*

National Population Policy, Action Plan 2000

Realize advantages of MVA by rationalizing requirements.

Deaths from unsafe abortion are the most preventable of all maternal deaths in many countries the goal of reducing maternal mortality by 50% would have been wholly achieved by simply eliminating deaths due to unsafe abortions

Ingar Brueggemann, Secretary General, IPPF

VACUUM ASPIRATION: GLOBAL EXPERIENCE

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PRESENTATION AT THE NATIONAL CONFERENCE ON MAKING EARLY ABORTION SAFE AND ACCESSIBLE, Agra, October 11-13, 2000

Vacuum Aspiration: Global Experience

Focus of talk

- Present worldwide experience of VA and D&C/ present review of literature
- Present scientific evidence of the advantages of VA (MVA and EVA) over D&C
- U.S transition to VA was largely responsible for shift to earlier procedures
- Go into greater depth about the advantages of VA, and MVA in particular
  - Greater safety
  - Simplicity and versatility of MVA
  - Aid to decentralization of services
- Address common misconceptions about VA

1. US 25 year experience: Vacuum Aspiration, either EVA or MVA, is preferred method

- By 1992, almost 98% of all US induced abortions were performed using Vacuum Aspiration (US Center for Disease Control, 1996)
- Largely responsible for a shift to earlier procedures that continues
- Largely responsible for a significant decrease in abortion-related mortality: declined 5 fold since 1973
- Potential of medical abortion as early abortion technique

2. VA is safer technique than D&C

- 25 years of clinical research in 100 countries involving over half a million women has proven that VA is safer and more effective than D&C
  - complication rates for VA are less than half that of D&C

3. Why VA is a safer method

- Plastic cannulae (VA) as compared to metal curette (D&C) means:
  - Little, if any, dilation required
  - Risk of uterine perforation is less
  - Risk of cervical tear is less
  - Less blood loss, according to studies
  - Less trauma to the endometrium
  - VA is less painful than D&C
  - Lower anaesthetic risks

4. However, advantages of VA are diminished with a 'curette check'

- Not needed for VA procedures
  - Vicious cycle of sharp curettage leading to more bleeding, which leads to more curettage which in turn leads to more bleeding and so on
  - 9 studies covering 15,000 MVA procedures and 46 studies covering 400,000 EVA procedures – without curette checks – demonstrated effectiveness rates (complete evacuation) exceeding 98%
  - A curette check adds unnecessary risk: increases pain and vagal reactions, increases chance of perforation and cervical laceration, increases bleeding etc.
  - Incidences of complete evacuation can be avoided by:
    - Appropriate sized cannulae
    - Examining the evacuated products for completion
    - Avoiding the mistake of stopping aspiration too soon
    - Noting signs of complete evacuation: a gritty feeling, and 'cramping' of the uterus

- Treatment for incomplete evacuation (including incomplete medical abortion) is re-evacuation using VA technique
- No evidence-based indication for 'curette check'

5. Myths about MVA

- 'Risk of HIV is higher with reuse of cannulae'
- 'Blood loss is greater with MVA or EVA'

6. Procedure safety and gestational age

- Infection prevention with bleach
- Abortion procedures at 7-8 weeks gestation have been shown to have the lowest major complication rates
- Major international studies for VA procedures through 9 weeks gestation
  - 12 studies in multiple countries, covering 210,164 cases found:
    - excess bleeding – 0.05-4.9%
    - pelvic infection – 0.1-2.2%
    - cervical injury – 0.01-1.6%
    - uterine perforation – 0.02-0.7%

7. VA is safer than D&C; early abortion is safer for both techniques

- Common complications of early procedures using VA are less common and easier to manage than those of later procedures and those done using D&C
  - Abortion procedures at 7-8 weeks gestation have lowest complication rates
  - Most common acute complication is cervical tear, which can be often repaired or referred
  - VA use is safer since only local anaesthetic is used, with no dilation
- VA is standard of care for:
  - Early induced abortion
  - Endometrial sampling (biopsy)
  - Molar pregnancy
  - Incomplete abortion (including failed medical abortion)

8. VA aids in the decentralization of services

- WHO: "because of the concern to improve access to health care, a common policy principle is the delegation of all tasks to the least trained person capable of performing them." (Care of Mother and Baby at the Health Centre: a practical guide. Geneva, WHO, 1994)
- Decentralization of health care services
  - Fewer complications with VA
  - Broader range of providers can provide services
  - Wider variety of settings
  - Most physicians and specialists do not work in peripheral settings
- Several countries have programs that allow 'physician extenders' to perform abortions
  - Bangladesh
  - South Africa
  - Vietnam
  - USA
- Procedures performed with abortion-related skills:
  - IUD insertion
  - IUD removal
  - Search for 'lost IUD'
  - Endometrial biopsy
  - Management of menstrual dysfunction

9. VA: cost-effectiveness

- Local or no anesthesia, No OT, No Anesthetist
- Procedure done in OPD, with minimal emergency equipment

- No need for overnight accomodations or staff
- Ability to utilize 'physician extenders'
- Cost reduction can be as much as 66% less (Kenya ; Mexico)
- Resources can be stretched further, aiding in decentralization.

10. 'Nature abhors a vacuum'. But does she have a preference?

- EVA is comparable to MVA
- Studies comparing the use of EVA and MVA technologies revealed equivalent high levels of effectiveness and low complication rates
- Complication rates for MVA vs. D&C are extremely low; complication rates for MVA vs. EVA are also lower
- Products of conception with MVA are intact – EVA (and D&C) are not
- In the U.S, the preference is EVA
- My preference is MVA
- MVA is multi-purpose
  - Re-evacuation treatment of incomplete abortions (medical or surgical), endometrial biopsies

11. Quality Training Improves Effectiveness

- Choice of cannula size
- Continue aspiration until procedure complete
- Attention to signs of completion
  - Uterine contraction
  - Patient demeanor
  - Uterine 'grittiness'
  - Tissue examination
- Effectiveness studies of MVA for both induced and incomplete abortions are very high (nearly 98% for each)

12. Other advantages of MVA:

- Improves patient-provider rapport
- Improves provider's ability to 'hear' the procedure
- Reduced patient noise-imprinting
- Reduces unnecessary workspace
- Allow for immediate identification of products
- Reduces dependence on assistant (and electricity and machinery – this is critical as PHCs do not usually have EVA machines or electricity)

EARLY MEDICAL ABORTION IN INDIA: THREE STUDIES AND THEIR IMPLICATIONS

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Agra, October 11-13, 2000

Early Medical Abortion in India : Three Studies and Their Implications

SYNOPSIS

Safety, efficacy and acceptability studies have been conducted in research, family planning clinic and rural settings. A combination of oral mifepristone 600 mg and oral misoprostol 400 mg were used for terminating pregnancies up to 63 days gestation. When comparing surgical with medical abortion, 88 % of women selected the medical method. Patient compliance was complete in 96 – 98% of women and the incidence of complete abortion not requiring any surgical intervention varied from 94 and 98 % in all 3 settings. There were no significant complications, women liked the method of medical abortion and the method was found to be acceptable and safe in both urban and rural settings.

MIFEPRISTONE TRIALS

Trial	Year	Environment	Situation
1	90-93	Research	China Cuba India
2	95-98	Urban FP	Pune Mumbai
3	95-98	Rural	Village Vadu

Population Council, New York

We have undertaken 3 Population Council trials over a 9-year period. Study 1 was a 3 country study conducted in China, Cuba and India in a research environment. The Indian arm of study 1 was conducted by Dr. Usha Krishna at Mumbai and myself at Pune.

MIFE-MISO VS SURGICAL ABORTION

CHINA CUBA INDIA

Safety, efficacy, and acceptability
Winikoff, Sivin, Coyaji, Cabezas, Bilian, Sujuan, Ming, Krishna, Eschen, Ellertson
A J Obstet Gynecol 1997;176:431-7

Side effects of mife-miso abortion
Elul, Winikoff, Coyaji.
Contraception 1999;59:107-114

Study 1 was a comparative trial of mifepristone-misoprostol versus surgical abortion. The safety, efficacy, and acceptability of medical abortion has been published in the American Journal of Obstetrics and Gynecology. The side effects of mifepristone-misoprostol abortion has been published, in the journal Contraception.

Today I would like to share with you my personal experience in the study conducted at the K.E.M. Hospital, Pune, which is a University teaching hospital.

STUDY PROTOCOL

DAY	PROTOCOL	DOSE	TIME
1	MIFEPRISTONE	600 mg	30 m
3	MISOPROSTOL	400 ug	4 h
17	EXIT INTERVIEW		

The study protocol consisted of giving 3 tablets, 600 mg of mifepristone, RU-486 orally on day 1. The client remained at the clinic for 30 minutes. 2 tablets 400 ug of the PG, misoprostol, were administered

48 hours later on day 3 and she was kept at the clinic for 4 hours. The client was called back for a final exit visit on day 17.

ACCEPTABILITY - CHOICE OF METHOD

	RU/PG	RANDOM	SURGICAL	TOTAL
CASES	125	1	16	142
%	88	0.8	11.2	10

(POPULATION COUNCIL KEM HOSPITAL PUNE 1990 -1993)

In this study we compared the client acceptability of medical abortion using the standard RU/misoprostol combination with surgical abortion. The client was given a choice of both medical and surgical methods and SHE decided her choice of method for pregnancy termination. If she could not decide, she was randomly assigned to one of the two groups. It is interesting to know that an overwhelming majority of women, 88 % chose the RU/PG combination. This obviously means that urban women, very much want a medical method for pregnancy termination.

REASONS FOR METHOD SELECTION

REASONS	RU 486 (n = 125)		SURGICAL (n = 17)	
	n	%	n	%
NO ADMISSION	61	49.6	1	5.9
FEAR OF SURG /TABS	61	49.6	3	17.6
CONVENIENT	50	40.6	2	11.8
CAN LOOK AFTER HOME	32	26.0	0	0
QUICK METHOD	1	0.8	6	35.3
KNOWN METHOD	0	0	6	35.3

(POPULATION COUNCIL KEM HOSPITAL PUNE 1990 -1993)

The reasons for method selection are numerous. Important reasons for selecting RU 486 were, no admission, fear of surgery, convenience, and the fact that it enables the mother to look after her home or job without any break. The important reasons for selecting the surgical method were that it is a quick and well established method, requiring a single intervention.

WORST FEATURES OF THE METHOD

WORST FEATURES	RU (n 123)		SURGICAL (n 17)	
	n	%	n	%
NO WORST FEATURES	98	79.7	14	82.3
PROLONGED BLEEDING	5	4.1	0	0
MORE BLEEDING	7	5.7	1	5.9
MORE VISITS	4	3.2	0	0
UNCERTAIN METHOD	6	4.9	0	0
NAUSEA	5	4.1	0	0
WEAKNESS	0	0	1	5.9
POTENTIAL FOR UT INJURY	0	0	1	5.9

(POPULATION COUNCIL KEM HOSPITAL PUNE 1990 -1993)

BEST FEATURES OF THE METHOD

BEST FEATURES	RU (n 123)		SURGICAL (n 17)	
	n	%	n	%
NO ADMISSION	61	49.6	0	0
FEAR OF SURGERY	52	42.3	0	0
CONVENIENT	60	48.8	1	5.9
CAN LOOK AFTER HOME	32	26	0	0
NO PAIN	42	34.1	6	35.3
QUICK METHOD	0	0	12	70.6
KNOWN METHOD	0	0	6	35.3

(POPULATION COUNCIL KEM HOSPITAL PUNE 1990 -1993)

At the time of the exit interview, the women were questioned about the best features of the method. No hospital admission, fear of surgery and convenience were the main features for the RU-misoprostol combination. Quick and well-established method were the main reasons for those selecting surgical abortion.

Similarly, the woman was asked the worst features of the method at the exit interview. The majority, 79.7 % in the RU group and 82.3 % in the surgical group mentioned that there were no bad features.

PATIENT COMPLIANCE

TOTAL	COMPLETE	
n	n	%
125	123	98.4

This slide shows the patient compliance for the 3 step protocol. Protocol violations were of 3 types. Those who did not come for the misoprostol tablets, those who were lost to follow up after taking misoprostol and those who had an unnecessary intervention. Out of 125 women who participated in the study in 123 women 98.4 % the compliance for the 3-step protocol was complete.

EFFICACY – COMPLETE ABORTION

TOTAL	COMPLETE	ABORTION
n	n	%
123	119	96.8

Out of the 123 women who completed the study, 119, 96.8 % had complete abortions. The study was highly successful with a large margin of safety, but it was in a research environment. The questions that came to my mind, pertained to service delivery of RU 486 when it became available in India. We had to be sure that it could work in the usual family planning clinic environment.

Further, what happens in villages? Remember, 73 % of Indians live in 600,000 villages spread over a vast geographic area. For a few rural women who can afford to pay, vacuum aspiration is available at private facilities in some villages. Rural women who are poor have access only to government run Primary Health Centres (PHCs). There are also many parts of India with no abortion facilities. So what happens in these situations?

MIFEPRISTONE TRIALS

Trial		Environment	Situation
1	90-93	Research	China Cuba India
2	95-98	Urban FP	Pune Mumbai
3	95-98	Rural	Village Vadu

Population Council, New York.

This concern motivated me to start trials 2 and 3 in a real life situation. Further, we thought it best to

integrate a medical abortion service with a family planning service.

Trial 2 was conducted at the urban family planning centers of the Bhatia Hospital, Mumbai by Dr. Usha Krishna and by me at the KEM Hospital, Pune. Trial 3 was conducted by me at the K.E.M. Rural Hospital, at village Vadu, situated 30 km from Pune, in a well-delineated rural community. The study design was similar to the previous one. Some of the more stringent exclusion criteria like previous uterine surgery were excluded. We have also included women up to 9 weeks of gestation in the urban arm.

Health education and awareness about health facilities can easily be communicated to women through mahila mandals. Before starting the rural study we attended these Mahila Mandal meetings. We described in detail the medical method of abortion to these women, made them aware of the potential for complications like bleeding and discussed possible solutions. We were happy to note that there was an overwhelming positive response.

Early medical abortion in India: Three studies and their implications for Abortion Services

Kurus Coyaji, *JAMWA. 2000; 55: 191 – 194*

Early medical abortion in India: Three studies and their implications for abortion Services which consists of the Pune arm of trials 2 and 3 have been published in the Journal of the American Women's Association.

Let me now share with you some of our results of trials 2 and 3 conducted at the Pune centre.

PATIENT COMPLIANCE

SITE	TOTAL	COMPLETE	
	n	n	%
URBAN FP	312	300	96.2
RURAL	300	294	98.0

This slide shows the patient compliance for the 3-step protocol. As can be seen in this slide there were very few protocol violators. The patient compliance was complete in 300 cases 96.2 % in the urban study and in 294 cases 98 % in the rural study. A significant point is that a high percentage of rural women adhered to the protocol. Further, it is also possible that some of the so-called protocol violators who did not come for the exit interview may have already aborted and hence did not come.

EFFICACY - COMPLETE ABORTION

SITE	TOTAL	COMPLETE	
	n	n	%
URBAN FP	300	284	94.7
RURAL	294	282	95.9

This slide shows the efficacy or the complete abortion rate. In the urban arm, out of 300 women 284, 94.7 % had complete abortions and in the rural arm, out of 294 women 282, 95.9 % had complete abortions. In both arms there was a high success rate.

SIDE EFFECTS MISOPROSTOL 0-4 HR

SIDE EFFECTS	URBAN N = 310 %	RURAL N = 299 %
BLEEDING	77.9	90.0
PAIN	74.0	82.0
NAUSEA	11.2	3.6
VOMITING	7.1	2.3
DIARRHOEA	2.6	0
FAINTING	1.6	1.7

(POPULATION COUNCIL KEM HOSPITAL PUNE 1995 -1998)

RU 486 itself has almost no side effects. The major side effects occur within 4 hours of misoprostol administration. This slide demonstrates side effects during that period. Bleeding and pain are the most common side effects. However they are both part of the abortion process rather than side effects of misoprostol. Nausea and vomiting could have been due to either the pregnancy or misoprostol. None of the women had a significant fall in haemoglobin levels and no women required blood transfusion.

In summary, women followed the protocol correctly and the staff grew confident. The method proved effective, acceptable, feasible and **above all safe**, in all settings. I stress the safety finding because unlike urban women in India who generally have access to some kind of surgical abortion service, many rural women currently have nothing.

My final vision for a developing country like India, would be to make SAFE medical abortion available in the cities of India as well as its nearly 600,000 villages; to make it available for all women, the rich, the poor, the educated, the illiterate, the liberated, the oppressed because it will contribute positively to the health and rights of women.

PROVISION OF MANUAL VACUUM ASPIRATION (MVA) SERVICES IN BANGLADESH

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Agra, October 11-13, 2000

Provision of Manual Vacuum Aspiration (MVA) Services in Bangladesh

A Profile of Women of Bangladesh

According to the 1991 census, the total population of Bangladesh was 111.5 million, with a density of 755 persons per square kilometer (GOB, 1994). Moreover, Bangladesh's population is growing. From 1981 to 1991, the population increased at the rate of about 2 million people per year.

Out of this total population, 48.6% (54.1 million) are women, 20% (22.3 million) are currently married women, and 17.4% (19.4 million) are currently married women of reproductive age (MWRA) between 15 and 49 (BBS, 1998).

Bangladeshi women are young. Of the 25 million women of reproductive age, 60% are between the ages of 15 and 29, the most fertile ages. Another 25 million young females will enter the reproductive ages while only 7 million will age out. This population momentum will continue to propel population growth even with dramatic reductions in fertility.

Most Bangladeshi women in their reproductive ages are married (78%). Bangladeshi women marry young (mean age at marriage 17.9 years; 1991 Census). Most Bangladeshi married women in the reproductive ages are sexually active, 81.1% of currently married women having had sexual relations in the past month (BDHS 1993-94).

Bangladeshi women start child bearing early. The median age at first birth for women aged 20-49 is 17.4 years (BDHS 1996-97) and almost 60% have begun childbearing by age 20. The total fertility rate declined sharply from 6.3 in 1975 to 3.3 in 1999-2000 (BDHS 1999-2000).

Overall, 54% of currently married women in Bangladesh are currently using a contraceptive method. Modern methods are much preferred (43% of married women) over traditional methods (10%). By far the most widely used method is the pill (23%), followed by female sterilization and injectables (7% each), periodic abstinence (5%), and condoms, and withdrawal (4% each).

Induced abortion and its tragic complications have been one of the most neglected health problems of the 20th century. Studies indicate that three quarters of maternal deaths in developing countries including Bangladesh are caused by one of the five obstetric complications, of which unsafe abortion is one. This is particularly tragic since deaths from abortion are almost completely preventable.

Relevant definitions

Abortion *is the interruption or termination of pregnancy from whatever cause, after implantation of the blastocyst in the endometrium and before the resulting foetus has attained viability (Tietze and Henshaw 1986).* ***Induced abortion*** *are those which are caused by deliberate interference. Induced abortion include those which are performed under legal sanctions and* ***Clandestine Abortions*** *are those which are performed outside the law.*

*The term **Unsafe Abortion** is usually used to reflect concerns for safety of abortion services. Unsafe abortions are characterized by the lack or inadequacy of skills of the provider, hazardous technique and unsanitary facilities. Unsafe abortion is the termination of pregnancy which is performed outside law and/or by untrained persons, and is a major direct cause of death among women of reproductive age (WHO, 1986).*

Legal status of abortion

Under the Indian Penal Code of 1860, induced abortion has permitted only to save the life of the mother. In 1972, the law was waived for women raped during the War of Liberation when abortions were performed in a few district hospitals under the guidance of expert teams from home and abroad. In 1976, legalization of first-trimester abortion on broad medical and social grounds was proposed in Bangladesh, but legislative action was not taken.

Introduction of Menstrual Regulation (MR): chronology of events

In 1974, the Bangladesh government encouraged introduction of Menstrual Regulation (MR) services in a few isolated family planning clinics. In 1978, a MR Training and Services Program (MRTSP) was initiated in seven government medical colleges and two-government district hospitals.

In 1979, the government included MR services in the national family planning program and encouraged doctors and paramedics to provide MR services in all government hospitals, health and family planning complexes (govt. circular BPCFPD Memo, May & December 1979). Citing a Law Institute paper, the government noted that MR is not regulated by the Penal Code, since pregnancy is difficult or impossible to prove. Rather, MR is said to an "interim method of establishing non pregnancy for a woman at risk of being pregnant, whether or not she actually is pregnant (Bangladesh Institute of Law and International Affairs, 1979).

As early as 1976 the Bangladesh National Population Policy attempted to legalize first-trimester abortions on broad medical and social grounds (Choudhary & Susan, 1975). As of 1985 this policy had not been implemented, and restrictive legislation remains in effect.[1] Nevertheless, a memorandum from the Population control and Family Planning Division (PCFPD) states categorically that "Menstrual regulation" (MR) is one of the methods used in the National Family Planning Program. The memorandum quotes a report from the Institute of Law (1979) to the effect that MR does not come under the provision of Penal code Section 312 in regard to abortion because pregnancy cannot be established.

Under statutory scheme, pregnancy is an essential element of the crime of abortion, but the use of menstrual regulation makes it virtually impossible for the prosecutor to meet the required proof. In Bangladesh menstrual regulation (MR) is being carried out till the tenth week following a missed menstrual period, and after that patients are referred as abortion cases. MR is now recognized as an interim method of establishing non-pregnancy for the woman who is at risk of being pregnant. Whether or not she is, in fact, pregnant is no longer an issue.

The Bangladesh government's Population Control and Family Planning Division (PCFPD) circular states that MR is included in the official policy and that a necessary logistic support for MR services and training will be provided by the Division.[2] Another Bangladesh PCFPD memorandum (1980) permits that MR can be performed by an MR-trained registered medical practitioner and by an FWV who has specific training in MR.[3] It also specifies that an FWV should perform MR only up to eight weeks from the last menstrual period, that is, four weeks from the missed menstrual period under supervision of a physician.[4] Any case with a longer duration must be referred to a trained doctor. In many government-supported clinics the procedure is performed by paramedics. The second Five-Year Plan released in 1980 envisaged that MR facilities would be provided through the family planning clinics, welfare centers, all health centers, and hospitals (Akhter & Rider, 1984b).

Notes

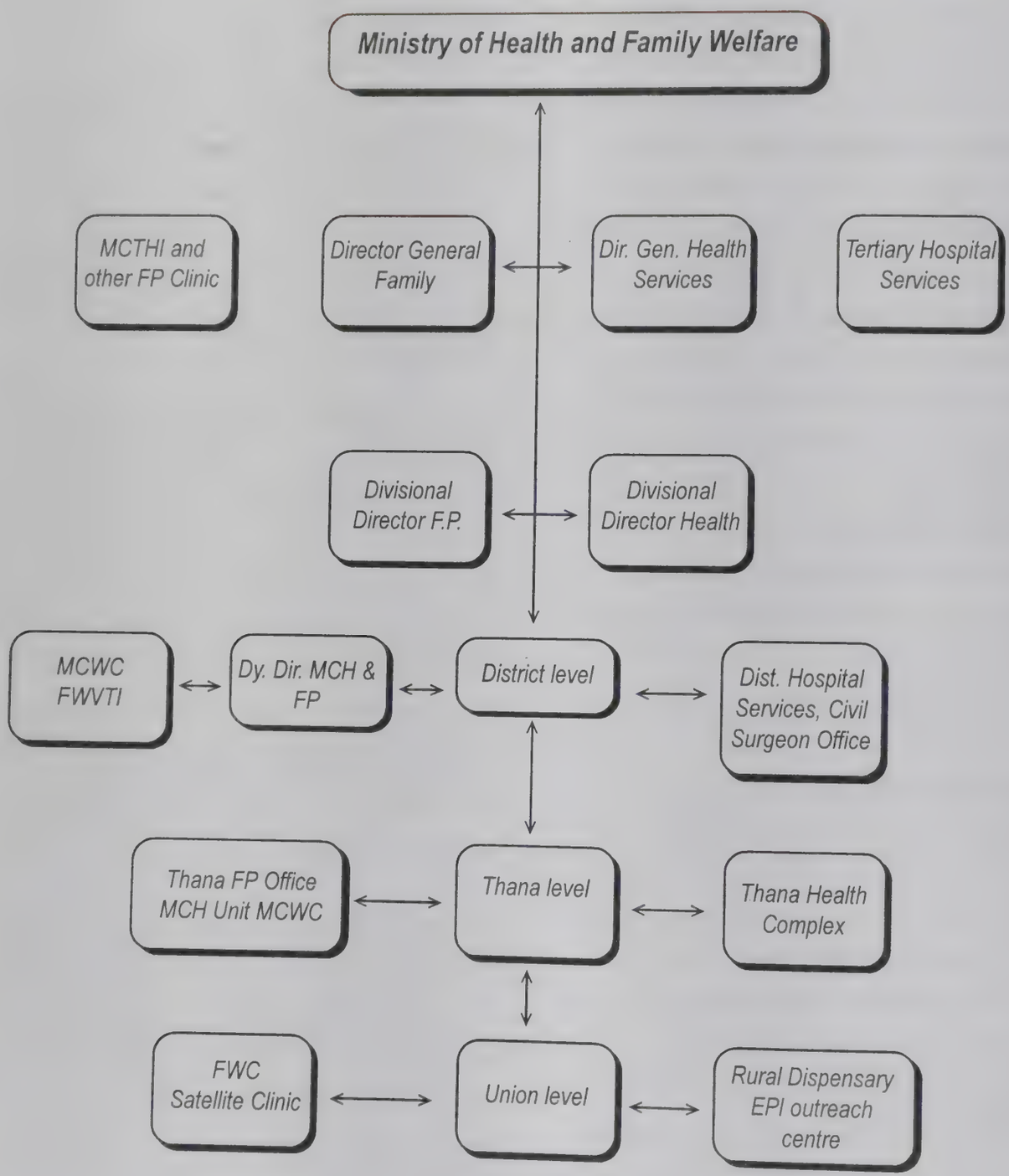
1. The abortion law of Bangladesh was patterned after British colonial law, and the influence of Islam may be the basis for its maintenance. Some scholars, however, interpret the Holy Quran as permitting abortion up to 120 days (sixteen weeks) (Al-Qaliqili, 1977) and believe that the current law is unduly restrictive. Other predominantly Muslim countries have widely varying laws ranging from one that permits abortion on request up to twelve weeks of gestation (Tunisia) to another that forbids abortion under any circumstances (Indonesia).
2. Government of People's Republic of Bangladesh Population Control and Family Planning Division Circular No. FP/Misc-26/79/278 (600), issued on 31 May 1979, announced that by 1982, all the headquarters of the country should be equipped with facilities to provide all types of family planning services such as MR, Sterilization, the IUD, and other contraceptive methods. Government of People's Republic of Bangladesh Population Control and Family Planning Division Memo NO. 5-14/MCH-FP/trg/79 dated 8 December 1979, Subject: MR Program.
3. Bangladesh Population control and Family Planning Division Memo No. 5-14/MCH/FR/trg/80, Subject : Guidelines for Menstrual Regulation (MR). This memo provided guidelines to regulate the services and ensure technical standards, including who can perform MR, criteria for MR training, national program support and supervision system.
4. Government of People's Republic of Bangladesh Population Control and Family Planning Division Memo No. 5-14/MCH-FR/Trg/79, National Institute of Population Research and Training. Subject : Arrangement for MR training for doctors and FWVs.

Current Status of MR services

MR training and service facilities were extended in phases and MR services are now available throughout the country. There are nearly 8000 doctors and 6500 paramedics trained on MR who are posted in different government clinics at national, district, thana, and union levels. Services are also provided privately by doctors and paramedics. The FWVs are constituting an important source of such service both in govt. facilities as well as in a private capacity, specially in the rural areas.

Currently, MR services in the public (govt.) sector are being provided by all medical college hospitals through Menstrual Regulation Training Services Program (MRTSP), Maternal and Child Welfare Center (MCWC), the District Hospital at the district level, the Thana Health Complexes at the thana level and the Family Welfare Centre (FWC) at the union level.

Health Facilities by administrative levels



MR Providers

MR providers with formal training, as noted earlier, are primarily physicians and female paramedics in government facilities. The Family Welfare Visitors (FWVs) are female paramedics who have at least ten years of formal schooling prior to their 18-month course in family planning and MCH. They learn to insert IUDs during their FWV course, MR techniques are taught through additional training through freshers and refreshers courses. About half of the doctors who obtain MR training are interns in the medical college hospitals; the rest are already employed in medical posts. Many private physicians also obtain training and provide MR services in their private practice.

Role of female paramedics as MR provider

Family Welfare Visitors (FWVs) trained on MR and posted in almost all Thana Health Complexes and all the Family Welfare Centers (FWCs) play an important role, not only by providing MR services but also by providing counselling and follow up to their clients. FWVs are posted in the most of 4500 Unions in the country, which serve 20000 to 25000 populations. Each FWV attends satellite clinics twice a week extending their services to the peripheral level. Role of FWVs are vital in minimizing the rate of rejection, because they come in contact not only with the women demanding clinical services but also with others while they are in the satellite clinics.

Training on Menstrual Regulation

The MR training and service organizations use three standardized training curricula: first time training for doctors, first time training for FWVs, and refresher training for FWVs.

Training protocol

- Every doctor trainee has to perform at least 20 MR cases independently and counsel 20 clients
- Every fresh FWV trainee has to perform at least 25 MR cases independently and counsel 25 clients and
- Every refresher FWV trainee has to perform 10 MR cases independently and counsel 10 clients

Training Curriculum: MRTSP were training curriculum for each category of trainees (doctor, fresh FWVs and refresher FWVs). The schedule is detailed day-to-day and covers a comprehensive range of topics for theoretical as well as practical hand-on training. For each category of trainees there are day to day training routines and schedules for all the centers of MRTSP to be followed by doctor and FWV trainees both fresh and refresher.

Counseling Training: As the field of MR is very sensitive and delicate, MRTSP centers along with its MR training also provides training in counseling.

Audio-visual training: Films on contraceptives and menstrual regulation are shown during training.

Standards:

- To qualify as having completed the training the trainees are required to have at least 80% attendance. There is supervision of adherence to training norms by the medical advisors who visit the centers time to time and report to the central office.
- Each trainee is trained under Infection Prevention (IP) protocol
- Each trainee must pass the post training evaluation test

- Materials to be received by each trainee after completion of the training
- Lecture on safety and comforts of clients is part of the curriculum.

Program Monitoring: In addition to the supervision and monitoring additional activities are also carried out by the central office of MRTSP for necessary monitoring of its performance.

Regulatory procedures for service – Government and other support

MR program is guided by a National Technical Advisory Committee headed by the Director General, Directorate of Family Planning and its members are from the Directorate of Family Planning and four non-government organizations, which play a prominent role in the implementation of the program and providing training. The government provides considerable support in the form of clinic space, salaries, and equipment for MR training and services. Until 1983, external funds were available from USAID, the Pathfinder Fund, and the Population Crisis Committee. In 1983-84 almost all non-government programs supported by USAID stopped providing MR services due to the U.S. government stance on abortion. At present only three programs, one government and two non-government, train government health personnel (doctors and FWVs) in the MR procedure.

In the government's Health and Population Sectoral Program (HPSP)for 1998 to 2003 has included menstrual regulation and unsafe abortion as one of the reproductive health car package.

The reproductive health care package contains following as its component:

- Safe Motherhood
- Family Planning
- Prevention and Control of RTI/STD/AIDS
- Maternal Nutrition
- Menstrual Regulation and Unsafe Abortion
- Adolescent care
- Infertility
- Neonatal care

This HPSP 1998-2003 of Ministry of Health and Family Welfare in its national Program Implementation Plan (PIP) has included one paragraph under the title of *"Menstrual Regulation (MR) and Unsafe Abortion"* as one of its **Reproductive Health Care Package:**

"Menstrual Regulation (MR) and Unsafe Abortion

Existing information suggests that each year about 2.8% of all pregnancies undergo MR and about 1.5% undergoes induced abortion. A significant amount of these are conducted in the public facilities, but undergo unsafe conditions. Although significant number of doctors and paramedics (about 12,000) received formal training in MR, and rate of complications and side effects have been reduced over time, still unsafe termination of pregnancies mostly occurs due to inadequate trained personnel and logistic support. In addition many women do not know of a provider or are not aware of time limits and access to legal MR services is poorer in rural areas than urban areas. These also contributed to the factors related to unsafe abortion and MR causing avoidable morbidity and mortality. Adequate

training and supplies has been ensured to minimize unsafe abortion or (unsafe) MR. MR activities will also play an important role in lowering the number of septic abortions with low complication rate and thus reducing morbidity and mortality due to illegal abortion." (HPSP PIP 1998, p-23).

Safe abortion services' is included as one of the interventions to prevent secondary infertility and is mentioned in the 'infertility' section of this HPSP document (HPSP,PIP, p-23).

Official reporting of MR procedures

The number of MRs officially reported to the Directorate of Family Planning include reports from MR training and service centers and some service centers is now approximately 120,000 in 98-99.

*Table 1. Performance statistics on M.R. Services **

Type of center	July to September,1999	Previous Financial year
Training cum-service centers	14,011	55,705
Service centers	15,887	64,292
Total	29,898	119,997

*Table 2. Performance statistics on M.R. training**

Name and location of the center, year, MR training started	Turnout of fresh traineès July'98 to Jun'99 (one year)		Total turnout (1975-99)		Turnout of refresher trainees July'98 to Jun'99	
	Doctor	FWV	Doctor	FWV	FWV	FWV
MFSTC'75	-	15	377	1364	12	686
DMCH'79	44	26	1265	182	13	127
SSMCH'79	53	22	1192	230	15	164
CMCH'79	10	10	798	502	3	175
RHCH'80	45	13	666	436	8	145
SBMCH'81	63	7	862	419	10	136
SMCH'81	38	14	695	295	4	112
MMCH'81	54	15	775	534	7	189
MSHP'81	17	13	246	465	8	153
KMCH'81	8	7	313	602	11	200
RMCHI'88	33	14	544	164	10	144

SHN'91	6	3	14	24	5	38
COMCH'98	-	-	-	2	3	4
MRTSP'79	371	144	7370	3855	97	1587
CCD'81	-	4	-	255	7	218
CCM'85	-	7	-	180	11	271
CCN'86	-	3	-	197	9	242
CCT'86	-	9	-	217	6	229
BWHC'81	-	23	-	849	33	960
Total	**371**	**183**	**7747**	**6068**	**142**	**3233**

Estimates of MR and induced abortion procedures

MRs are also performed privately by doctors and FWVs, by other medical personnel and traditional practitioners without formal training. Accurate estimates of the annual number of MR procedures performed in the country are not available. This may be primarily due to the tendency of MR performers to under-report the performance, as they also perform, in their private practice. Estimates of induced procedures based on the interviews with the practitioners are in the range of 400,000-500,000 (Sing, 1998).

Utilization of MR services and knowledge about MR

Respondents in the 1996-97 BDHS were also asked if they knew about or had ever used menstrual regulation (MR). Results shown in Table 3 indicate that almost 4 in 5 ever-married and currently married women know about MR, in contrast to only half of currently married men. Ever use of the method is negligible, however, with only 3-4% of women and about 5% of men saying they had ever used MR. Levels of ever use are highest among respondents who are currently in their late 20s and 30s.

Table 3. Menstrual regulation

Age group	Ever-married women	Currently married women	Currently married men
Know of menstrual regulation	**78.2**	**78.9**	**52.1**
Ever used menstrual regulation			
10-14	0.0	0.0	-
15-19	1.5	1.6	-
20-24	2.1	2.2	-
25-29	4.9	5.1	-
30-34	5.3	5.7	-

35-39	4.5	4.8	-
40-44	2.9	3.2	-
45-49	1.6	2.0	-
Total	**3.4**	**3.6**	**4.8**

Note : Data are not shown for men by age group due to small sample size

Inspite of the widespread availability of MR services, utilization remains low, especially among high parity less educated rural woman. There could be a number of reasons which may include religious and political reasons, MR related messages are not publicized women learn about MR services through word of mouth communication through the MCH-FP field workers, Family Welfare Assistants (FWAs), TBAs through another women. The FWAs visit households and educate women on MCH-FP, one FWA cover about 800 households and there are a total of about 23,500 FWAs in the country.

Rejected MR

In the MRTSP training centers MR is performed from 6-8 weeks by FWV and doctors using Manual Vacuum Aspiration (MVA) and from 8-10 weeks by doctors using Electric Vacuum Aspiration (EVA).

A study findings *(Kamal et al.,1990)* observed that nearly one-third of women seeking MR services were rejected. Most of the rejections were due to pregnancy durations longer than 8 weeks. Many of the rejected MR clients resort to dangerous indigenous methods of abortions. About one-fifth of maternal mortality are attribute due to traditional unsafe abortions. An analysis of 11,470 MR rejected clients show the following reasons for rejection.

Table 4.
Reasons for rejections of MR seekers at the MR clinics

REASON	***N=8810***
Longer duration of pregnancy	92.6
Medical reason	0.1
Repeated MR discouraged	0.8
Caesarian operation done before	0.8
Others	5.7

All the rejected MR clients, except for only 1.1% had pregnancy duration of more than 10 weeks.

There was a varied number of reasons for clients reporting late to the clinic. However, over four-fifths (83.6%) of the clients could not report to the clinic within the acceptable duration of pregnancy due to the following reasons:

- Due to irregular menstruation she could not be sure about the pregnancy / could not realize that she got pregnant 28.0%
- Shortage of money/companion/time/went to village home 16.2%
- Tried elsewhere 15.9%
- Address of the center was not known/it was not known that MR can be done 14.4%
- Ignorance about the duration up to which MR is done 9.1%

Clandestine abortion and maternal mortality

Although menstrual regulation has become increasingly available in recent years, clandestine abortion is still widely practiced in Bangladesh, especially in rural areas. In Bangladesh clandestine abortion complications still constitute one of the major causes of maternal mortality and morbidity. Approximately half of the admissions to gynaecology departments of major urban hospitals are due to complications of unsafe abortion *(Begum, Khan & Jahan, 1978)* which include sepsis, temperature, and pelvic infection, which these complications are direct consequence of unsafe procedures. Complications are mostly occur in those cases which are induced by inserting objects such as a stick or a root into the uterus.*(Akhter 1994)*.

In 1996, over a five-month period in 16 THCs, 8 district hospitals, 10 MCWCs and 4 medical colleges of 4 administrative divisions, a total of 628 complicated abortion cases were admitted. Based on this study findings the annual number of complicated abortion cases treated in the impatient department of 13 medical colleges; 64 district hospitals and 460 thana health complexes has been estimated to be 14,427. However, the cases who came for treatment in the outpatient of these facilities and the non-government hospitals were not included.

Table 5.

Annual Number of women complicated with abortion complications admitted in hospital facilities for treatment

Inpatient govt. facilities	Medical College (13)	District Hospital (64)	THC (460)	Total
No. of facility interviewed	4	8	16	28
Total complicated abortion cases in 5 months	329	176	123	628
Total complicated abortion cases in 1 month per facility	16	4	2	22
Total complicated abortion cases in 12 months per facility	197	53	18	268
Total complicated abortion cases admitted per year	2561	3379	8487	14,427

One study using indirect estimation techniques found estimated annual number of induced abortion complications to be 52,426 in 1996 where they have included abortion cases treated in outpatient department as well as in 333 non government hospitals nationwide (Singh S, 1997)

Conclusion

Service provision related issues should be identified, addressed and emphasized on a continuing basis which may include, quality of care provided to MR clients and medical standards of service delivery as well as training facilities.

Studies have observed that even medically trained paramedics like nurses and family planning workers induce abortion in hospital setting as well as in home setting.

They need to be oriented, streamlined and followed up to help them provide care through medically approved standards and qualities.

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PROVIDING SAFE ABORTIONS FOR WOMEN IN SOUTH AFRICA

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Providing Safe Abortions for Women in South Africa

The Choice on Termination of Pregnancy (CTOP) Act, SA

- The CTOP Act was introduced on the 1st of February, 1997.
- The new Act was introduced as part of an effort to promote reproductive rights and choice for all women.
- The CTOP Act was also introduced to contribute to the reduction of maternal morbidity and mortality.
- The CTOP Act is directly in the line with the Constitution of South Africa which promotes and protects the basic human rights of all South Africans.

The Choice of Termination of Pregnancy Act, South Africa

The Act was introduced on the 1st February, 1997

- Upon the request of a woman during the first 12 weeks of the gestation period of her pregnancy.
- Under defined circumstances between the 13th – 20th week.
- Under very limited circumstances after the 20th week.

The Choice on Termination of Pregnancy Act, South Africa

- The CTOP Act permits a medical practitioner, or registered midwife who has completed the prescribed training course to perform a termination of pregnancy (TOP).
- Registered midwives may only perform TOP's of up to 12 weeks gestation
- A surgincal termination may only take place at a facility designated by the Minister of Health.
- The Act promotes the provision of non-mandatory and non-directive counseling, before and after the termination of a pregnancy.

Information Concerning a TOP

The Act specifies that woman requesting a TOP must be informed of her rights in terms of the Act. A health care provider must give a woman the following information :

- She is entitled to a TOP upon request in the first 12 weeks
- The circumstances under which she can get a TOP from the 13th – 20th week.
- Only her consent is required for a TOP.
- Non-mandatory, non-directive counselling is available.
- The locality of facilities for TOP.

Consent for a TOP

- A TOP may only take place with the informed consent of a pregnant woman.
- No consent other than that of the pregnant woman is required for the TOP.
- In the case of a pregnant minor, a medical practitioner, or registered midwife, should advise the minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. However, the TOP cannot be denied if the minor chooses not to consult with them.
- Where a woman is severely mentally disabled

or in a state of unconsciousness the pregnancy may be terminated upon the request of her guardian, spouse or curator personae with the consent of two practitioners.

Promoting Access to TOP's

- The provision of TOP's are not limited to Gynaecologists.
- A 'medical practitioner' means a person registered under the Medical, Dental and Supplementary Health Professionals Act.
- An appropriately trained medical practitioner may perform a TOP of any gestation.
- By allowing for midwives with the prescribed training to provide TOP's, services can be decentralised to the primary care level.
- Midwives are trained nurses with at least 4 years professional training after basic schooling.

Promoting Access to TOP's

- TOP's are provided free of charge at all levels of care within public sector facilities.
- Only woman's consent is required for TOP, even the pregnant minor.
- The identity of the woman who requested a TOP is to remain confidential on breach of confidentiality the provider shall be guilty of an offence and liable on conviction to a fine, or to imprisonment for a period not exceeding 6 months.

Promoting Access to TOP's

- The CTOP Act also provides that :

"Any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for a termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years".

Implementation of the CTOP Act

- After the passing of the CTOP Act steps had to be taken to ensure that the Act could be implemented to provide women with access to TOP services
- Values clarification workshops, for health care providers were conducted around the country.
- A National Abortion Care Programme was set up to train doctors and midwives to provide TOP's, and to provide post abortion contraceptive counseling.
- A National TOP Advisory Group was established to review progress in training and service provision.
- The Reproductive Rights Alliance undertook to monitor progress in implementation.

Values Clarification for TOP

Values clarification workshops aimed to :

- Give health care providers time and space to reflect on their feelings and thoughts about abortion.
- Encourage providers to attend to women requesting a TOP in a non-judgmental way.
- Help providers find ways to relate their values and belief systems to the needs of clients.
- Encourage providers to treat women seeking an abortion with dignity and respect, regardless of their own personal views.
- Educate providers about the provisions of the new Act.

The National Abortion Care Programme

The National Abortion Care Programme consists of three main activities :

1. Training of doctors in the MVA technique.
2. Training of midwives in abortion care (including the MVA technique).
3. Training of Midwives in post abortion family planning counseling.

Training of Midwives to Provide Abortion Care in South Africa

The Abortion Care Midwife Training Programme consisted of 3 main activities :

1. Development of the abortion care curriculum.
2. Training of midwives in abortion care.
3. Evaluation of midwives' practice.

Methods of TOP

- The main method used for TOP's both physicians and midwives is vacuum aspiration.
- Midwives are trained to use manual vacuum aspiration.
- Misoprostol is used for cervical priming prior to the TOP procedure in all cases by both physicians and midwives.
- D & C is rarely used (no midwife does a D & C).
- Medical methods of abortion are currently being considered.

Misoprostol Regimens

- There is no uniform regimen for misoprostol use.
- Midwives trained to use ff: 600 microgms pv 2-4 hours before the procedure on site.
- Other regimens include : 600 microgms pv/po 12-14 hours before the procedure off site (misoprostol given to women to take home and insert day before procedure).
- 400 micrograms dose of misoprostol pv 2-4 hours prior to procedure has also shown to be effective.
- Pv dose has less side effects, direct and more sustained action.

The Midwife Abortion Care Training Programme

- The Midwife Abortion Care Training Course is a short course certified by the South African Nursing Council.
- The total duration of the course is 160 hours, with 80 hours of theoretical training and 80 hours clinical training.
- Clinical training is done by experienced practicing physicians in designated hospitals.
- Certification of midwives is only after successful completion of both theory and clinicals.

The Midwife Abortion Care Training Programme

The Abortion Care Course aims to teach midwives :

- To provide a holistic approach to the provision of abortion services.
- To provide comprehensive services to women seeking abortion care (TOP's and incompletes $\leq$ 12 weeks).
- To stabilise and refer women with abortion complications.
- To link abortion services with post TOP contraceptive services and follow-up care.
- To link abortion services with other reproductive health services.

The Midwife Abortion Care Training Programme

By the end of the training the midwife should be able to :

- Assess clients and establish the gestational age of the pregnancy.
- Provide pre and post TOP counseling.
- Perform essential pre-TOP investigations.
- Diagnose and manage STI's.
- USE MVA to terminate a first trimester pregnancy.
- Provide appropriate pain control for a TOP.
- Institute emergency treatment, if required, during a procedure.
- Provide contraceptive methods post TOP.
- Provide comprehensive patient education on contraception, STI's HIV/AIDS, and safe sexual practices.
- Make appropriate referrals.

The Midwife Abortion Care Training Programme

Training Curriculum Modules

- Pre Course Module –

Anatomy and Physiology

1. Overview of TOP
2. Legal aspects of TOP
3. Professional practice and ethics
4. Communication skills and counselling techniques
5. Client assessment and preparation
6. Applied pharmacology
7. MVA technique
8. Infection control
9. Management of complications
10. Post abortion contraception
11. Organising and managing services

The Midwife Abortion Care Training Programme

- TOT approach was used, at least two providers in each of nine provinces trained as trainers.
- Midwives trainers train other midwives in the theoretical aspects of abortion care.
- Only experienced practicing physicians train midwives in the MVA technique.
- Minimum number of 20 abortions have to be performed under supervision.
- Midwives certified only after successful completion of both theory and practice.

Evaluation of Midwife Abortion Care Services

About a year after the programme was started an evaluation of the midwives' services was undertaken. The objectives of the evaluation were to :

- Determine the number of TOP services established and run by certified midwives.
- Evaluate the quality of care provided in midwives' services.
- Assess the technical competence of midwives.
- Provide logistical and technical support to practicing midwives.
- Develop prototype service evaluation forms.

Evaluation of Midwife Abortion Care Services

The following aspects of the midwives abortion care services were evaluated :

- Clinical services.
- Contraceptive services.

- Service statistics.
- Patient satisfaction.

Evaluation of Midwife Abortion Care Services

Abortion Care Clinical Services (Interviews and Observation)

- Assessment of clinical technique (MVA), pain management, counselling and communication techniques.
- Availability of IEC materials, review of protocols.
- Supervision.

Evaluation of Midwife Abortion Care Services

Abortion Care Contraceptive Services (Interviews and Observation)

- Client – Provider interaction, counselling and communication techniques, accuracy and completeness of information given to clients.
- Staff training in family planning.
- Availability of contraceptive methods.
- Barriers to providing counselling and methods.

Evaluation of Midwife Abortion Care Services

Service Statistics (Review of records)

- Caseload statistics, accuracy and completeness of log books and client charts.

Patient Satisfaction (Interviews)

- Waiting times, information given, pain experienced, overall satisfaction with services.

Training of Midwives in Abortion Care

- Evaluation showed that midwives are providing high quality services.
- Midwives can be trained to use simple, cost-effective techniques to provide safe abortions.
- Midwives can provide abortion care services independent of physicians.
- The training of midwives has greatly improved access to abortion services in South Africa

Critical Issues in Promoting Access to Safe Abortions

- ***It is not just a liberal law that matters but systematic, and co-ordinated implementation of the law***
- ***Promoting access to safe abortions is a challenge that requires committed people who will rise to the challenge***

PSS EXPERIENCE OF EARLY ABORTION SERVICES

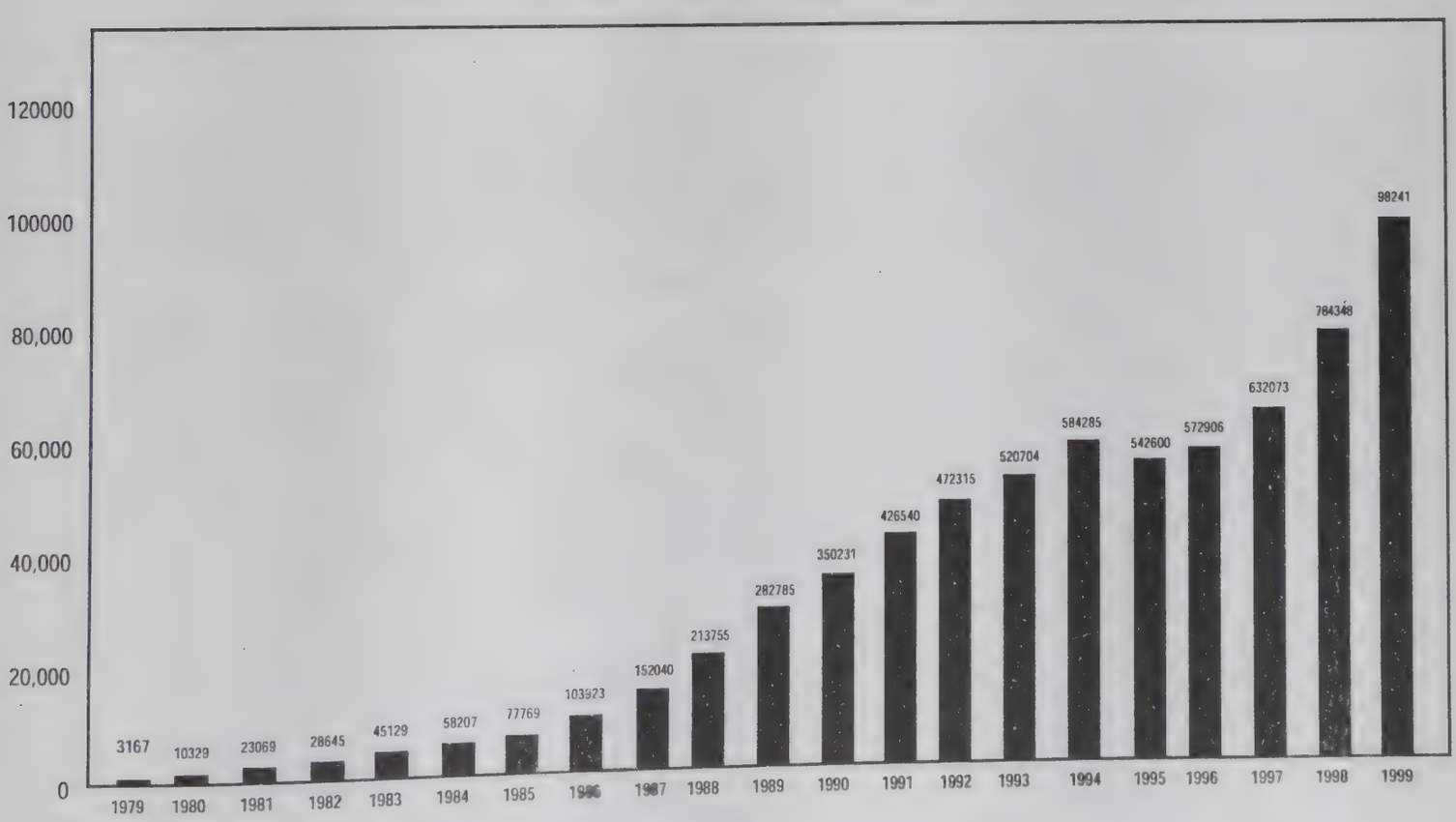
Dr. B. Kalpagam
MARIE STOPES CLINIC
(A Project of Parivar Seva Sanstha)

PRESENTATION AT THE NATIONAL CONFERENCE ON
MAKING EARLY ABORTION SAFE AND ACCESSIBLE
Agra, October 11-13, 2000

PARIVAR SEVA SANSTHA

STATUS	Registered Society/NGO
REGISTERED IN	1978
AFFILIATED WITH	MARIE STOPES INTERNATIONAL
MISSION	To improve the reproductive health of people with emphasis on "Children by Choice Not Chance
GOAL	Prevention of unwanted births
AREAS OF WORK	16 States

COUPLE YEARS PROTECTION PROVIDED BY PARIVAR SEVA SANSTHA
(SINCE INCEPTION TO 1999)



Main Thrust Areas of PSS

- Social Marketing of Clinical Services
- Social Marketing of Products
- Outreach and Community Activities

Our Philosphy

- Wide range of affordable quality services
- Meeting customers expectations
- Small effective team
- Multi-skilled, multi-tasking providers
- Improvement in efficiency
- Paramedicalisation

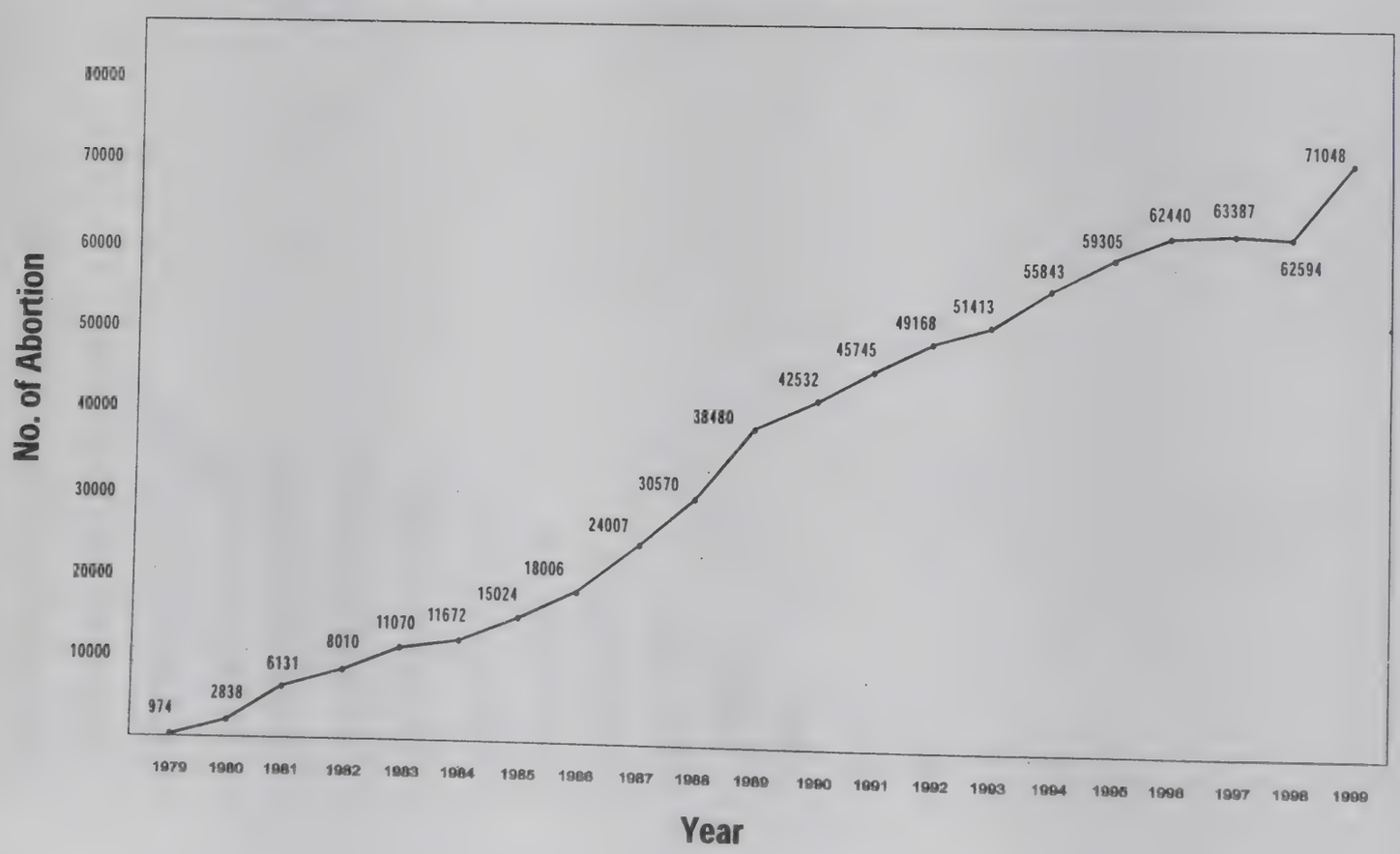
Clinic Services

- Counselling
- Contraceptives
  - Temporary
  - Terminal
- Emergency Contraceptives
- Safe Abortion
- Maternal Health Care
- RTI & STI management
- Gynae checkup
- Infertility
- Medicheck
- Immunizations

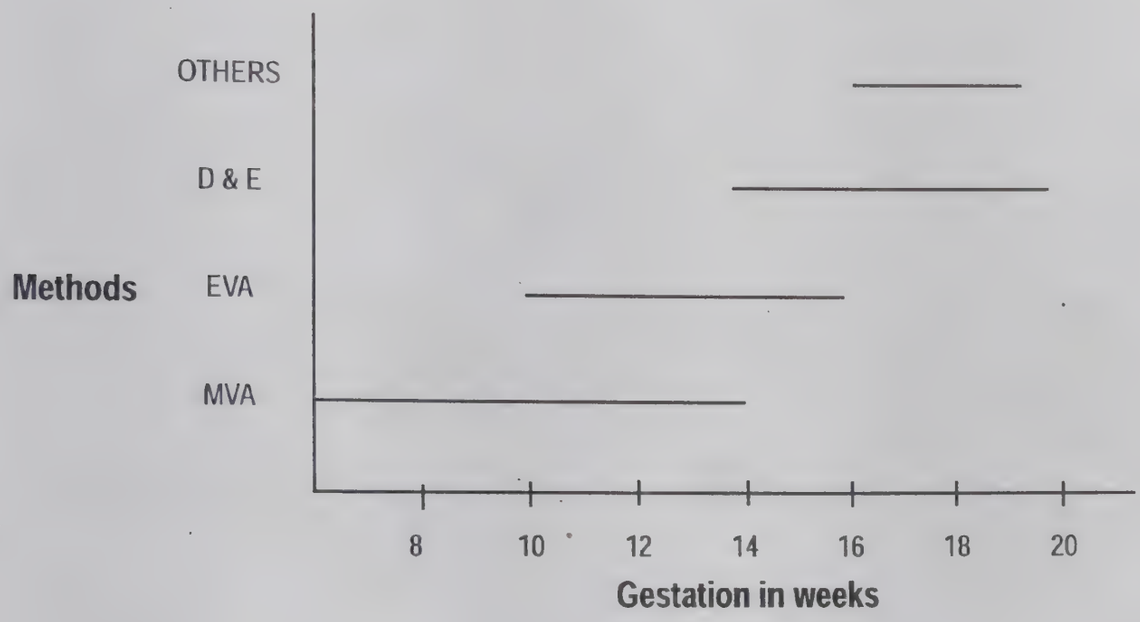
PSS Frame Work of Abortion Services

- Services Delivery Site
- Team of Service Providers
- Training and Skill Development
  - Induction training
  - Refresher training
  - Supportive Supervision
- Client Selection
  - Counselling
  - Medical Evaluation
- Post abortion care and contraception

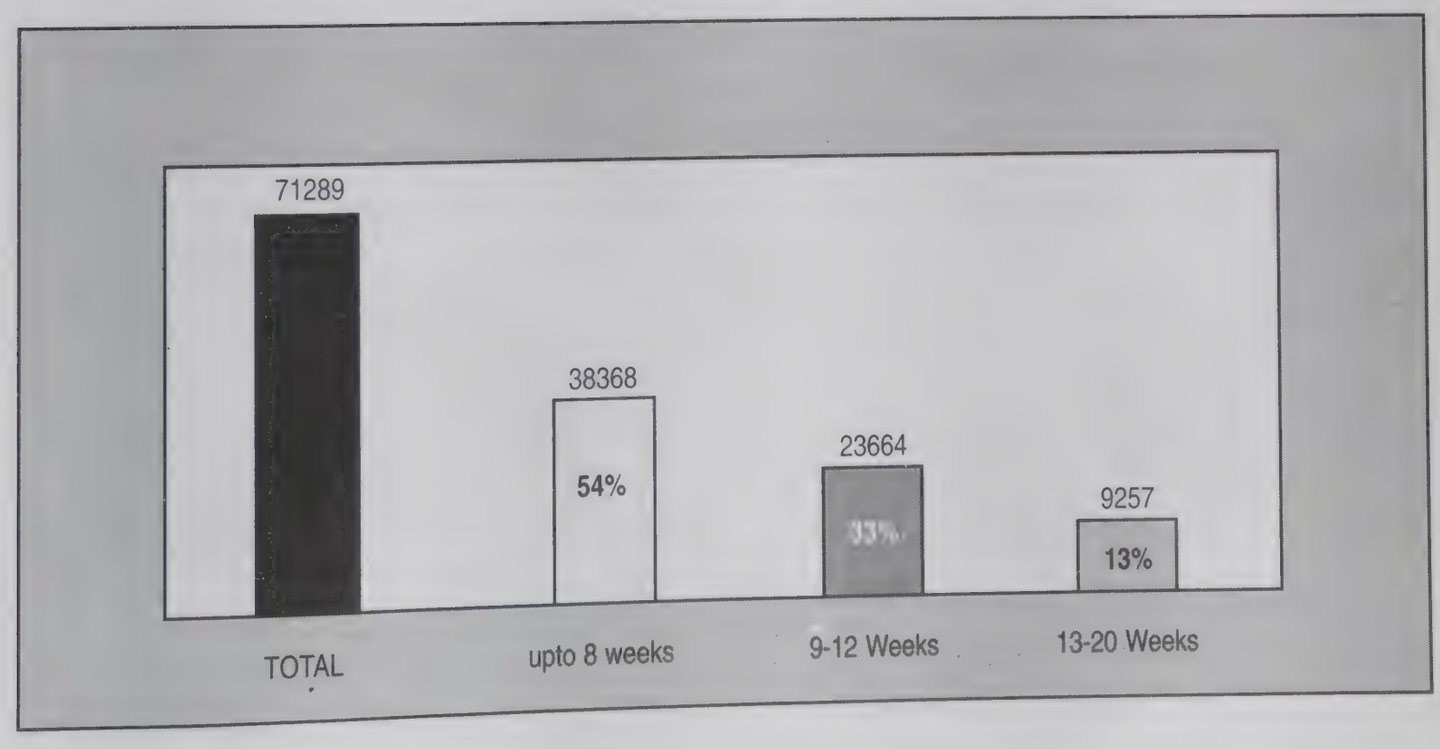
MTP's PERFORMED SINCE INCEPTION



Gestationwise - Abortion Procedure



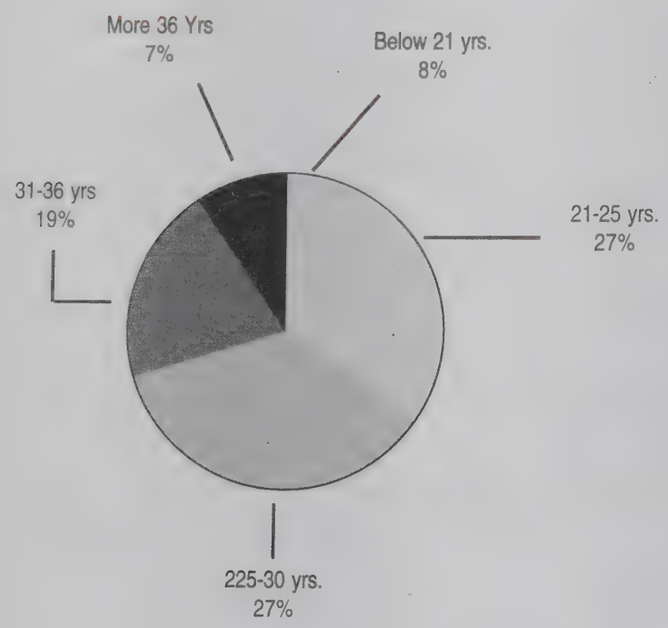
PSS EXPERIENCE OF ABORTION SERVICES
(1999-2000)



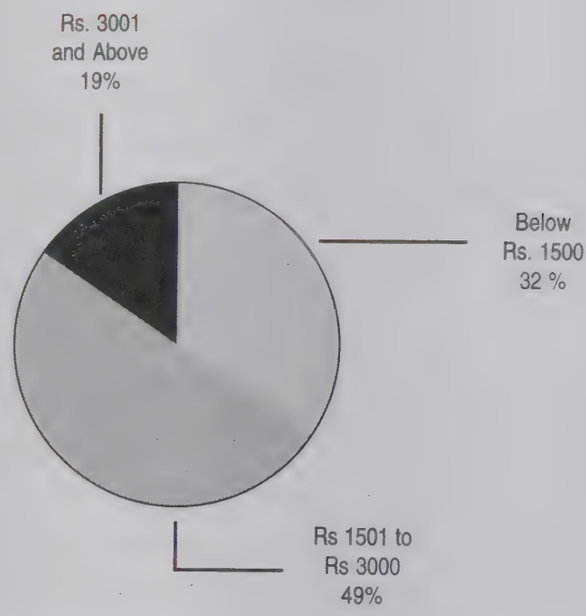
1ST TRIMESTER ABORTIONS

Our Client Profile (1999-2000)

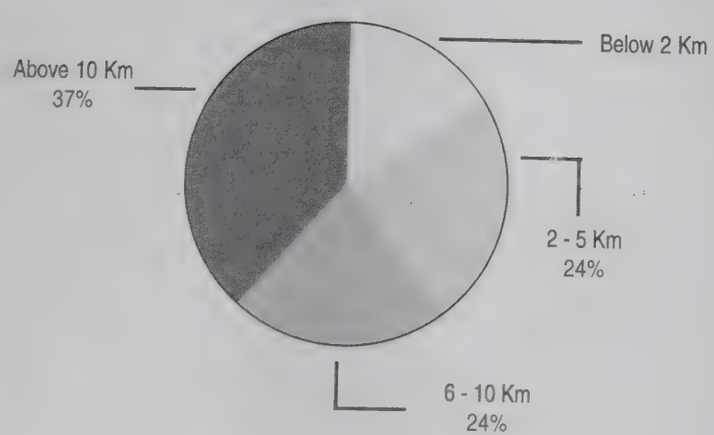
AGE



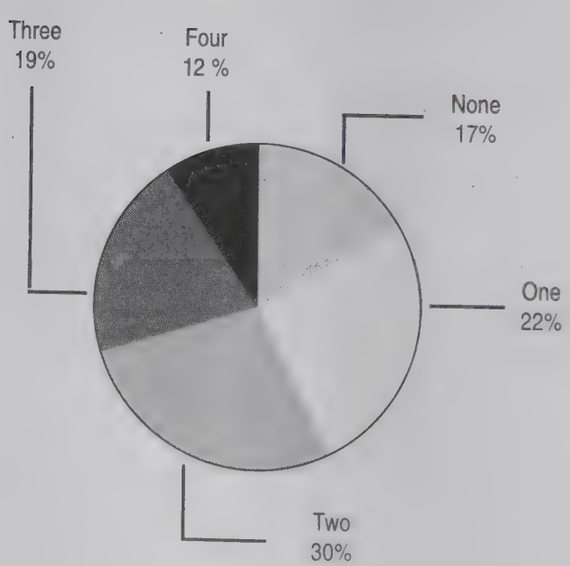
INCOME



RESIDENCE DISTANCE

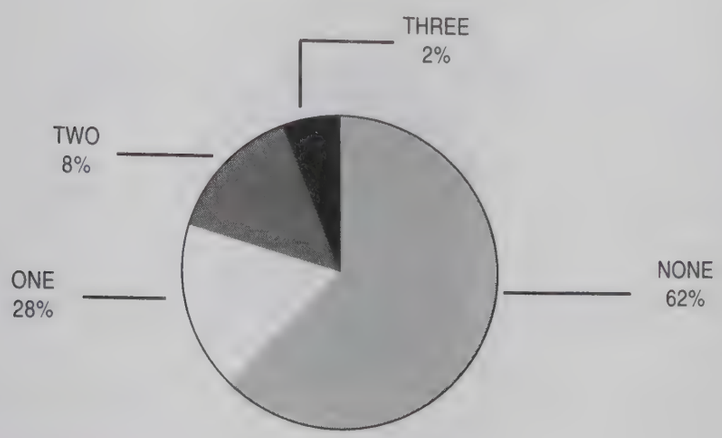


PARITY



Our Client Profile (1999-2000)

NO OF PAST ABORTIONS



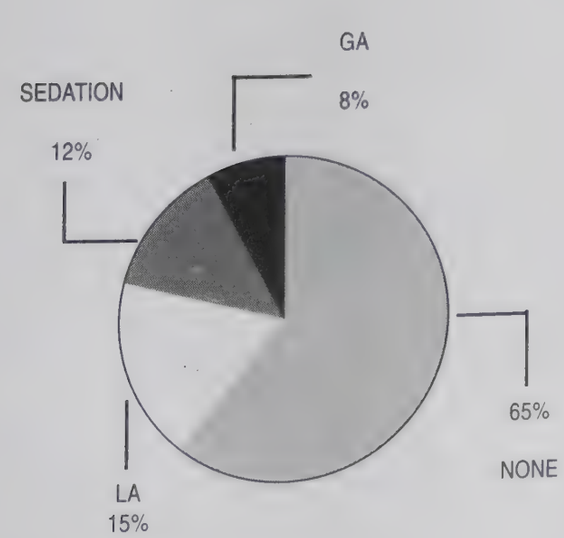
Method of Abortion - MVA

Advantages

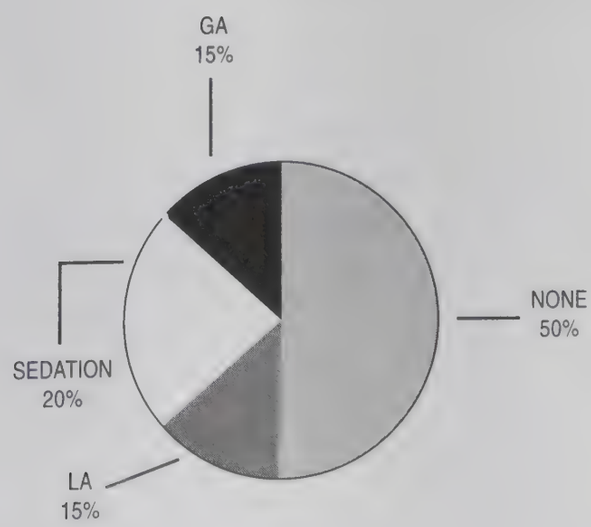
- Hand operated simple and safe
- Electricity not required
- Noiseless
- Simple Instruments and easy maintenance
- Dilators not required
- Minimum recovery time
- Visualisation of Gestational Sac

TYPES OF ANAESTHESIA

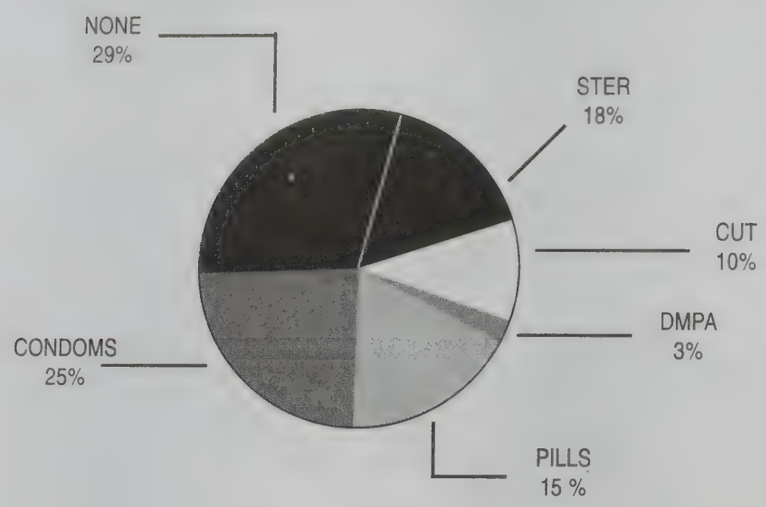
0-8 WEEKS



9-12 WEEKS



POST ABORTION CONTRACEPTIONS (UPTO 12 WEEKS)



COMPLICATIONS ENCOUNTERED IN 1ST TRIMSTER CASES (1999-2000)

	0-8 Wks n=32027		9-12 Wks n=21412	
	n	%	n	%
Reaspiration	265	0.82%	235	1.10%
Continuation	24	0.10%	-	-

CONCLUDING ADDRESS

Mr. Gautam Basu
Joint Secretary (Family Welfare)
Ministry of Health & Family Welfare
Government of India

CONCLUDING ADDRESS AT THE NATIONAL CONFERENCE ON MAKING EARLY ABORTION SAFE AND ACCESSIBLE, Agra, October 11-13, 2000

Concluding Address

At the outset, I felt very sorry for not being able to attend fully in all the sessions in this important conference, as there was another meeting going on in Agra where my presence was also required. However, I was kept appraised about the proceedings and also whatever sessions I could attend particularly in some of the work groups, I have no hesitation to say that this conference is really a national consultative meeting, perhaps the only thing lacking is of more participation from State Government officials than just one only. However, this is definitely a major beginning and I have no iota of doubt that things will move fast from this point.

When the Government of India first launched the RCH programme in October, 1997, there was a clear consensus that maternal health is of concern to all, mainly the issues related to safe abortion, RTI/STD, problems of life cycles of women etc. It is known that illegal abortion is a major cause of maternal death and this has outnumbered the legal ones, inspite of the country's legislative MTP programme over the last 3 decades. The failure of the MTP programme probably may be due to insufficient training of service providers, strict and cumbersome regulations for site certification equipment of sophisticated nature, not looking at our need and non availability of safe abortion services at every place particularly in rural areas.

India needs the information and lessons learnt from other countries. The recent WHO consultative meeting held at Geneva in September, 2000, where a large contingent from India participated (from Government, NGO and private sectors) alongwith other developing and developed countries, brought out several important points and experiences. The lessons from Turkey and South Africa which could reduce illegal abortions after legalisation of abortion services to a significantly low level within few years, is something one has to learn. In this country inspite of legalization of MTP since last 3 decades, illegal abortions are still high and the utilization of legal services during last decade remain either at a plateau, or dwindling. The time has come to look at the experiences of other countries across the globe, the ways they have achieved and the technological advances. India possibly has only been comparing their own performances and then starts rectifying. It is high time that we must look at our neighbouring countries and study their experiences. Bangladesh for example is doing a good job in reducing illegal abortion by legislative backing. The Government of India is looking at the whole MTP Act and at rules which were framed in 1971 and trying to make the guidelines more simpler.

In the presently implemented RCH programme, there are two important components – (i) training of service providers and (ii) equipping the MTP clinics both at governmental and public/NGO sectors. Funds for these are available in plenty, but unfortunately most of the funds are not utilized by the various State governments. The allocation of fund was kept more for MTP services as demand for this was thought to be also from private/NGO sectors, but in fact there was very little demand. This fund can be utilized for purchase of electrical items, equipment, training etc.

This meeting with a combination of various stakeholders like government, NGOs, OBGYN experts, professional bodies like FOGSI, nursing councils and other international experts, has provided a definite platform for exchange of ideas, views, experiences and come out with workable suggestions. According to me this conference has brought out two important gains – (i) Loud and clear recognition of MVA (Manual Vacuum Aspiration) for early abortions as a technique. The main task of ours is to ease the utilization of this facility, by large scale use of NGO and private sector service delivery sites alongwith the governmental set up. In fact as the RCH programme has a lot of flexibility which allows NGO/ private sectors to keep and work with governmental set up particularly in UP, MP, Rajasthan and Bihar. (ii) To look at the possibility of bringing in mid level providers in delivery of early abortion services. In the rural areas, there is a great dearth of qualified doctors, which will be there for next 2 to 3 decades, as with the increase in the cost of medical education it is not possible to have enough qualified doctors to run every PHC of the country. Therefore properly trained, motivated and dedicated nurses and midwives need to be placed and allow them to provide early abortion services, which can only ease the service load at the peripheral level. This obviously needs amendment of existing MTP Act, which can only be done through national debates. The proposal of this type needs to be sent to all the ministries of the Central Government, State Government, women's organization, professional bodies, NGOs, OBGYN experts, nursing council etc and then have several regional and state level meetings at every part of the country to have a consensus. But, before that there is a need to look at the existing facilities and identify the requirements like service delivery site, who can certify, training needs, type of providers and their skill, equipment necessary, type of procedure to be done etc. then we will be ready for the national concessions.

Therefore, I suggest Mrs. Sudha Tewari to constitute one "working group" immediately with representatives from Government, NGOs, private sectors, OBGYN experts and other professional bodies. This working group should work on all the issues related to safe abortion services and come out with a set of recommendations within next one year or at least one and half years for discussion. This package will help government of India in formulation and implementation process, as also gain political support in making early abortion safe and accessible.

By and large, apart from the needs for abortion services upto 8 weeks and 12 weeks gestations, this conference has achieved much more than what I expected. It is heartening that if this type of conference of two days can achieve so much concretely, then obviously the country is heading for a big change and I therefore request all of you to work hand in hand in the larger interest of the country to safeguard womens health and bring down maternal mortality and morbidity. As regards, the governments direction one need not have any doubt, as in RCH programme, MTP is a major issue and the fact that National Population Policy – 2000, has gone out of the way twice and mentioned MTP as a major issue, including MVA as a procedure and use of mid-level providers in service delivery. Therefore, direction has already set by the government much

before this conference has taken place. You may know that MTP is a document which is approved by Prime Minister of India and also Prime Minister heads the commission which implements MTP. The National Population Commission has set up a working group for 'MTP and MCH issue' and I am a member in that. I am sure all these issues will be discussed in the first meeting of the working group.

At the end, I recommend that we should have annual meetings of this type every year around October/ November and take stock of the situation, how far we have gone. This is a major beginning and we must keep it up. Lastly, I am deeply impressed with all the good works and efforts done in this conference by all the participants and thankful to Mrs. Sudha Tewari for organizing this type of conference alongwith Ipas and set a platform for all the stakeholders to meet, deliberate and discuss.